

FUNERAL DIRECTOR: IMPORTANT

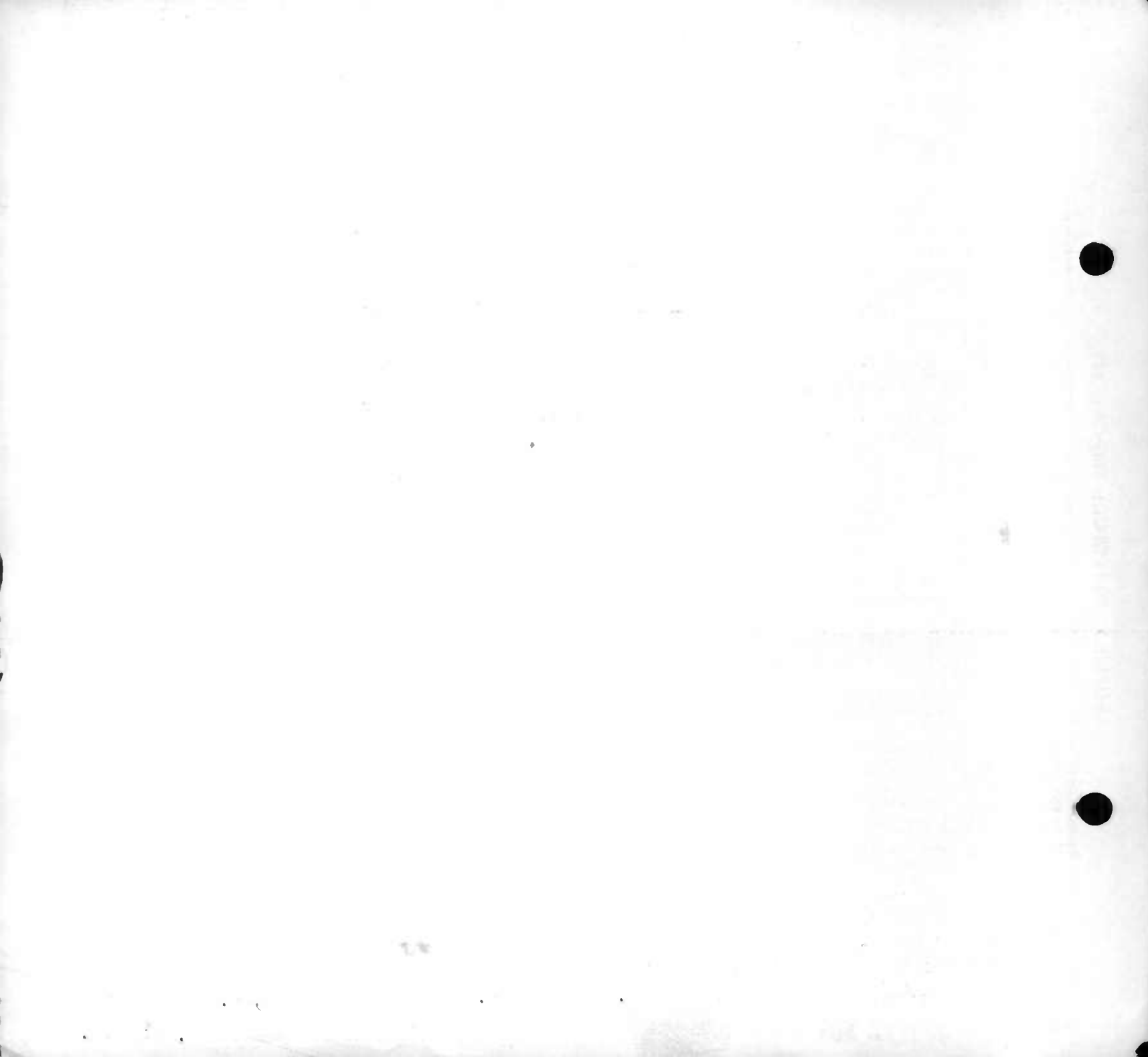
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 3501	
CERTIFICATE OF DEATH					
BIRTH NO. Q-200		1. NAME OF DECEASED (Type or Print) QUASKY JOHN PAUL		2. DATE AND HOUR OF DEATH APRIL 7th 1971 11:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2102		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1312 JAMES ST. BALTO. MD. 21223		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/19	9. AGE (In years last birthday) 51	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY AUTO PARTS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FREDERICK QUASKY			
14. MOTHER'S MAIDEN NAME AGNES KNELL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/>			
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT FANNIE QUASKY same as above.			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIO SCLEROSIS (B) DUE TO, OR AS A CONSEQUENCE OF: CEREBROVASCULAR ACCIDENT (C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 20th 1971 to April 7th 1971 that (I) (we) last saw the deceased alive on April 7th 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Cabrera M.D.				23B. DATE SIGNED 4/7/71	
23C. PHYSICIAN'S NAME (Type) JUAN M. CABRERA M.D.				23D. ADDRESS UNIVERSITY OF MD. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/71		24C. NAME of CEMETERY or CREMATORY Green Haven Cem.	
24D. LOCATION (City, town, or county) (State) Green Burial Md.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Moran + Son Inc.		ADDRESS 901 Helms St. 38nd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

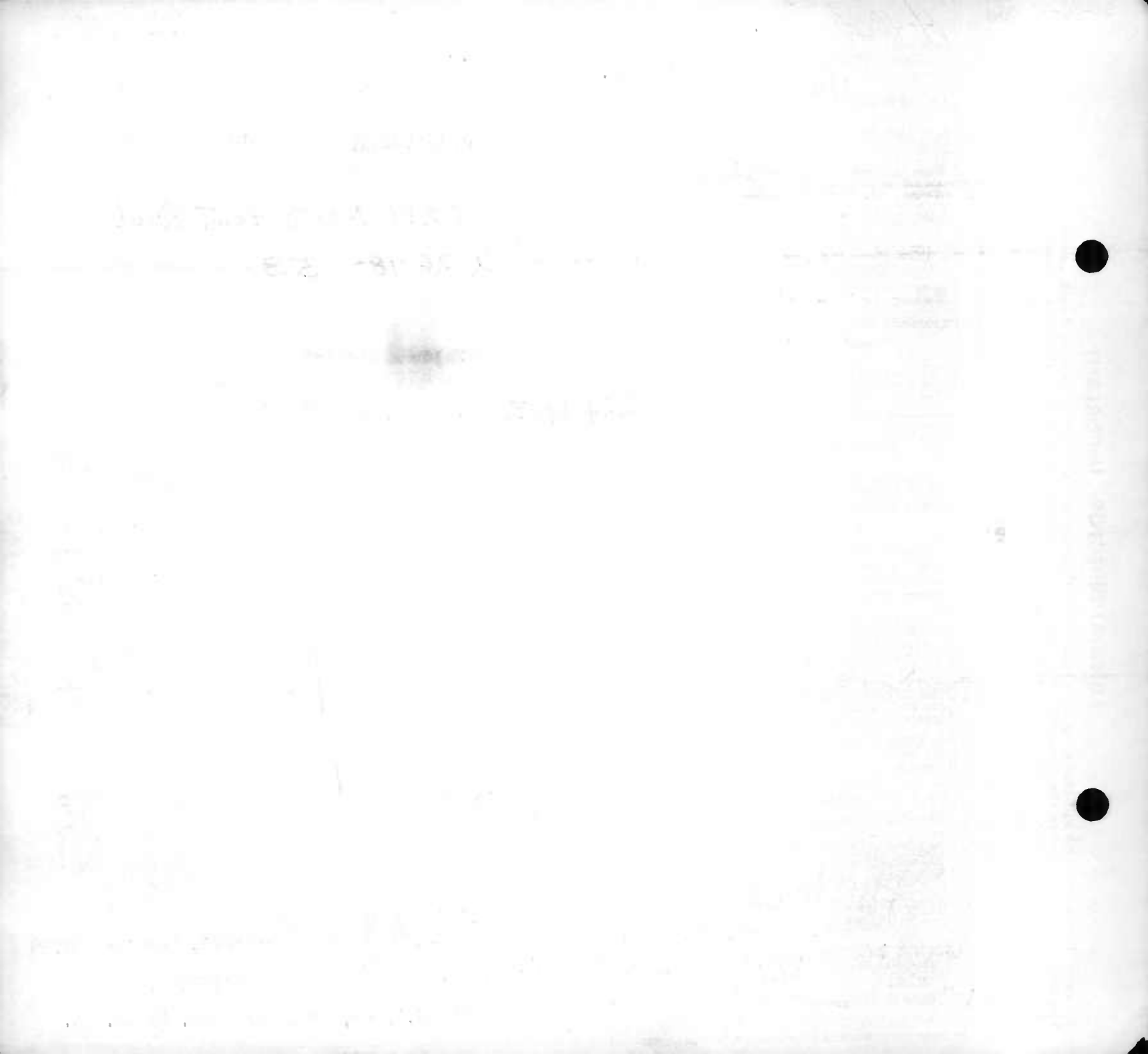
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____	
G-600 71 3502 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Albert Henry Gray</u>		2. DATE AND HOUR OF DEATH <u>4/9/71</u> <u>1:40</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt. City</u>		5. CITY OR TOWN <u>Baltimore</u>		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		8. STREET AND NUMBER <u>1014 Scott Street</u>			
9. SEX <u>M</u>	10. RACE <u>W</u>	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH <u>7/29/91</u>		13. AGE (in years last birthday) <u>79</u>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		15. KIND OF BUSINESS OR INDUSTRY <u>1/1/1</u>		16. BIRTHPLACE (State or foreign country) <u>Vermont</u>	
17. FATHER'S NAME <u>unknown</u>		18. MOTHER'S MAIDEN NAME <u>unknown</u>			
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>yes</u> <u>WW 1</u>		20. SOCIAL SECURITY NO. <u>unknown</u>		21. INFORMANT <u>Hosp. chart</u>	
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		24. CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocardial Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u>	
II					
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
27. DATE OF OPERATION <u>0</u>		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No) <u>No</u>	
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I certify that (I) (this hospital) attended the deceased from <u>4/6/71</u> 19 <u>71</u> to <u>4/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/8/71</u> 19 _____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
37. SIGNATURE <u>Hubert T. Gurley MD</u>				38. DATE SIGNED <u>4/8/71</u>	
39. PHYSICIAN'S NAME (Type) <u>Hubert T. Gurley MD</u>		40. ADDRESS <u>University Hospital</u>			
41. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		42. DATE <u>4/12/71</u>		43. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	
44. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		45. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>			
46. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		47. FUNERAL DIRECTOR <u>Mc Gully Funeral Home 130 E. Fort Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

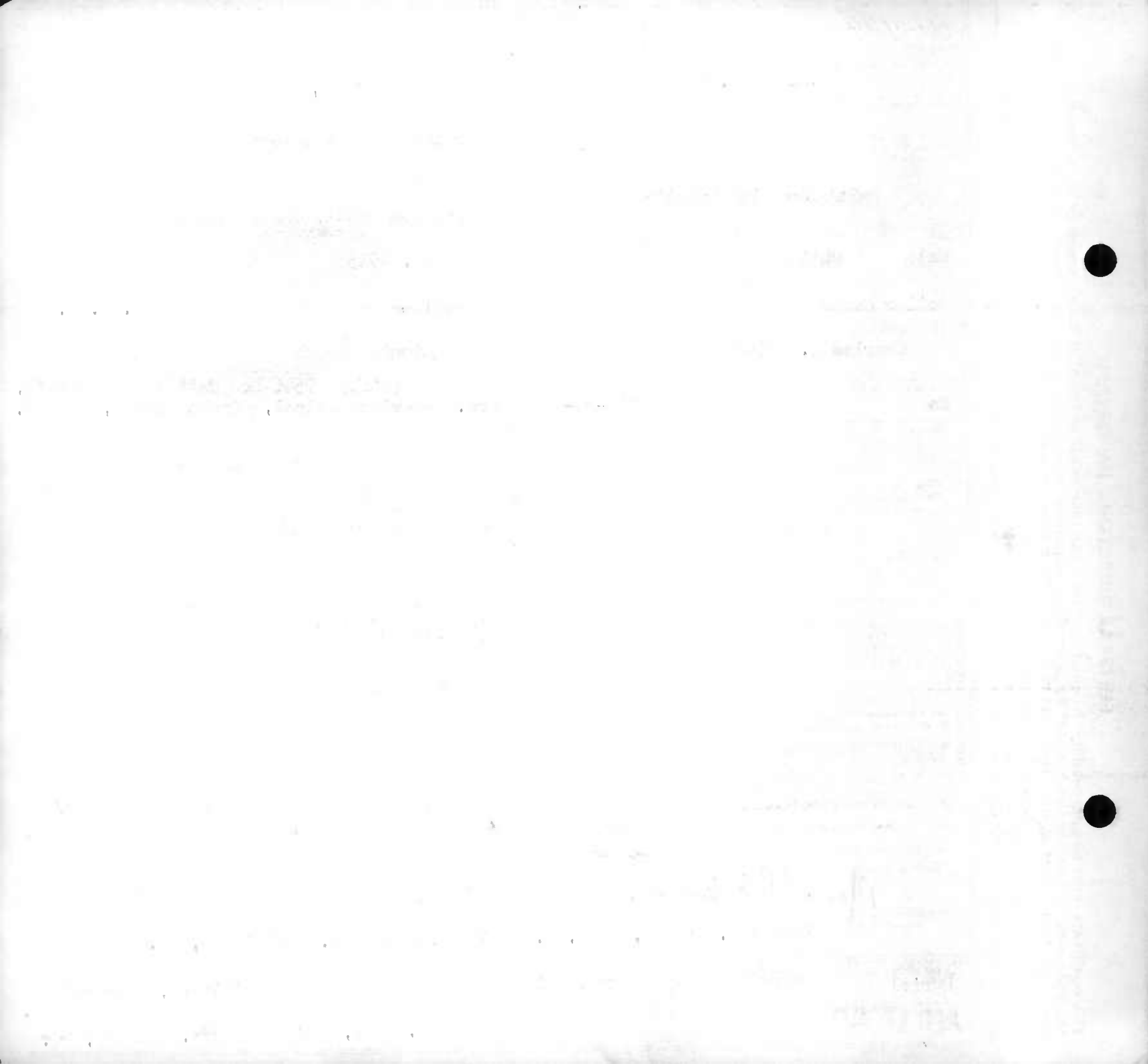
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 3503		CERTIFICATE OF DEATH		REG. NO.		71 3503	
1. NAME OF DECEASED (Type or Print) <u>Hall, Lina</u> <u>Lina J. Hall</u>				2. DATE AND HOUR OF DEATH <u>April 5, 1971</u> <u>10:00 A. M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> <u>Baltimore</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				C. CITY OR TOWN <u>Edgemere</u> <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>7219 North Point Road</u> <u>21219</u>					
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/26/18</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady - Waitress</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hall</u>				14. MOTHER'S MAIDEN NAME <u>Melinda Whorley</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>224-14136</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: Records</u> <u>Baltimore, Maryland 21224</u>			
18. <u>486 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Massive Aspiration</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Empyema - ? Bronchopneumal fistula</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>4 weeks</u> <u>1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>71</u> to <u>4/5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10 AM</u> <u>4/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>John M. Kellum, Jr.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/5/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>John M. Kellum, Jr.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>		25B. NAME OF REGISTRAR <u>Blair E. ...</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>7922 Wise Ave. Balto. Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

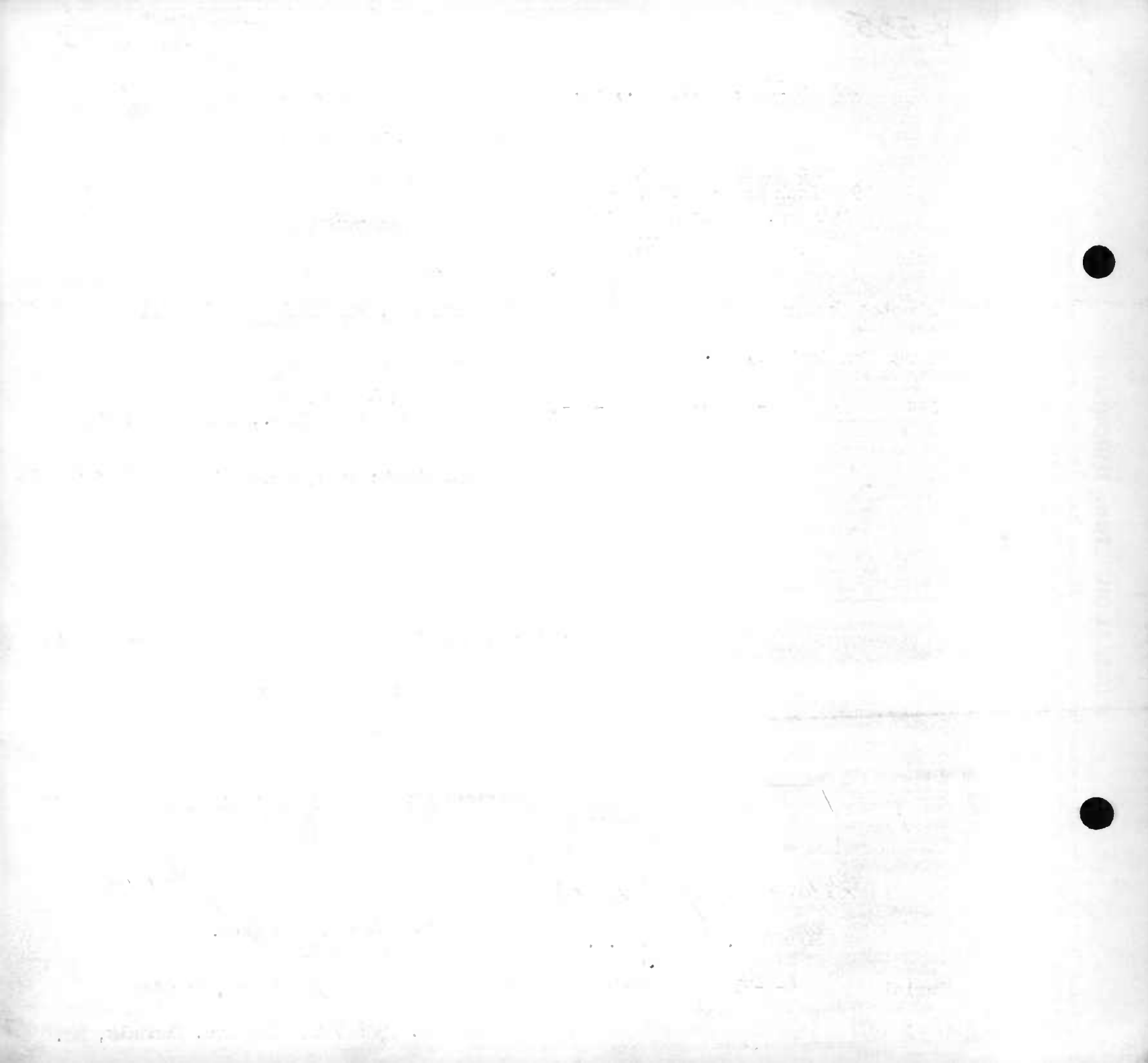
W-424		71 3504		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 3504	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				HOWARD L. WELZEL			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH April 4, 1971			
FULL NAME OF HOSPITAL OR INSTITUTION				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				A. STATE B. COUNTY			
31 Baltimore City Hospital				Maryland Baltimore			
				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				Dundalk YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER			
				7546 New Battle Grove Circle			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 31, 1915	
						9. AGE (In years last birthday) 56	
						10. Under 1 Mo. 1 Yr. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Boiler Maker							
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland				U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles L. Welzel				Minnie Dorsch			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				213-07-6740			
17. INFORMANT (Wife) 7546 New Battle				ADDRESS Dundalk, Md.			
Mrs. Genevieve Welzel, Grove Circle,							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Coronary Occlusion			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Anterior Septal Heart Disease			
				(C)			
II				Diabetes Mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (who hospital) attended the deceased from 26 2 19 68 to 11 15 19 71 that (I) (who) last saw the deceased alive on Jan 15, 1970 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Manuel P. DeLeon				4/6/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Manuel P. DeLeon, M. D.				7840 Eastern Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/7/71		Oak Lawn Cemetery		Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 12 1971		John J. Duda		7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

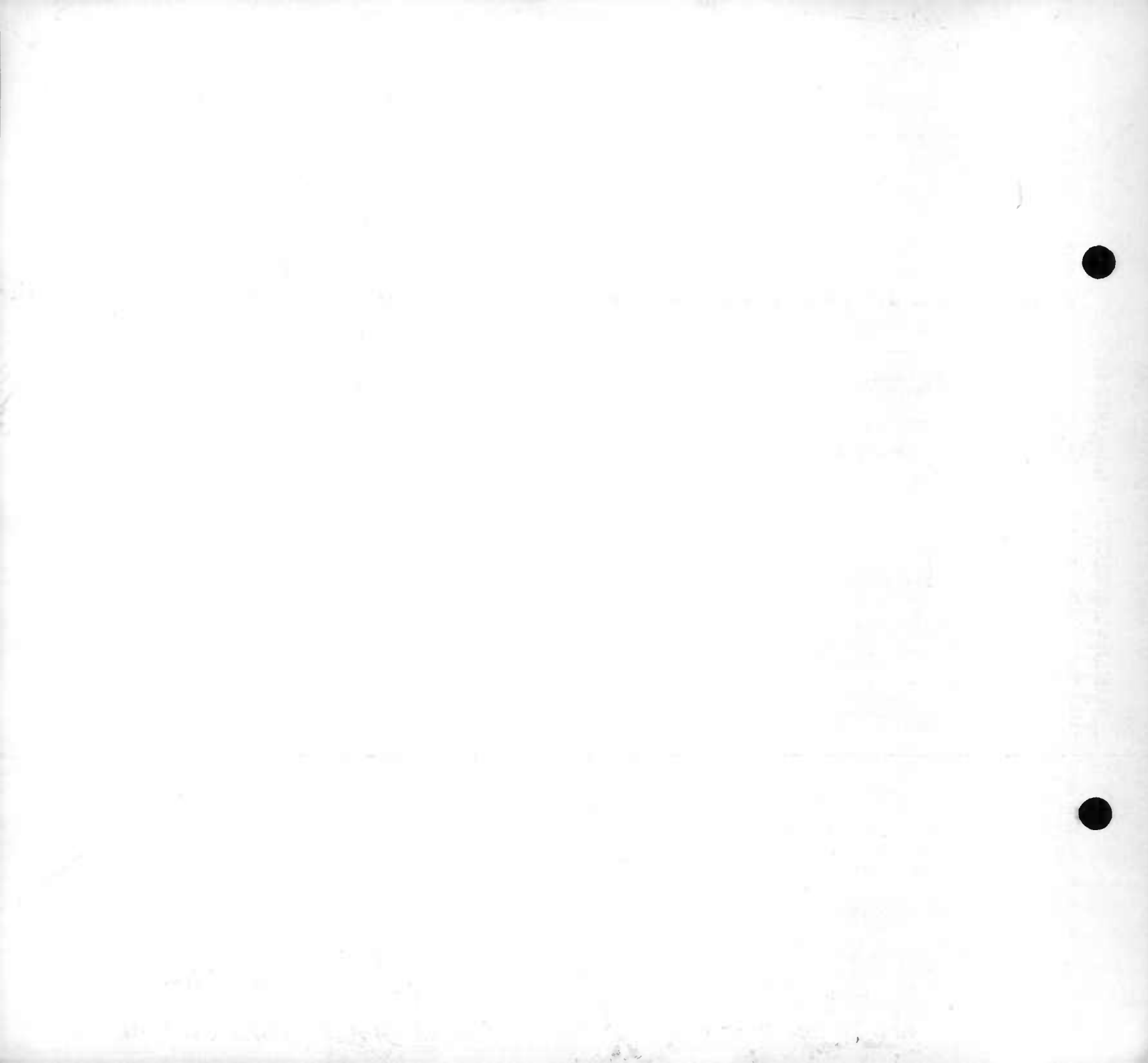
BIRTH NO. V-535 71 3505				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3505	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
VAN DANIKER, George E., Jr.				4/4/71 12/21 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland Baltimore 5300			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male White				Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				8. DATE OF BIRTH		9. AGE (In years last birthday)	
Asbestos Worker				2/11/34		37	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
unemployed				Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Van Daniker, Sr.				Sarah Neary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes 5/25/54 - 5/24/56				212-30-4435		VA Hospital Records 3900 Loch Raven Blvd., Balto Md 21218	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Metastatic carcinoma of lung 3-6 months			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				(D) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Cachexia and Inanition 2 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from March 31 3/31 19 71 to April 4th 19 71 that (I) (we) last saw the deceased alive on April 4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Robert Daryl Fisher M.D.						4/5/71	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
ROBERT D. FISHER, M.D.						3900 Loch Raven Blvd. Balto Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-7-71		Gardens Of Faith		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
APR 12 1971		Robert E. Fisher, M.D.		John J. Duda 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3506
CERTIFICATE OF DEATH				REG. NO. _____
BIRTH NO. <u>H-525</u>		71 3506		
1. NAME OF DECEASED (Type or Print) <u>HAZEL HANSON</u>		2. DATE AND HOUR OF DEATH <u>APRIL 8, 1971 6:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1307</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND</u> <u>38 HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LICENSED NURSE</u>		8. DATE OF BIRTH <u>UNKNOWN</u>
13. FATHER'S NAME <u>—</u>		14. MOTHER'S MAIDEN NAME <u>—</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JAMES PHILIPS (ATTORNEY)</u>
18. <u>410.941.250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTICEMIA</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCTION</u>		<u>10 DAYS</u>
		(B) <u>ASCVD DIABETES</u>		<u>?</u>
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>APRIL 30</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TRACHEOSTOMY FOR ADEQUATE SUCCTION</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>March 27</u> 19 <u>71</u> to <u>April 8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Jaime F. Casella M.D.</u>		23B. DATE SIGNED <u>APRIL 8, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>JAIME F. CASELLA M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>4/9-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Green Hills</u>
25A. DATE REC'D BY HEALTH/DEPT. <u>APR 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sparks Funeral Home</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25D. ADDRESS <u>814 W 36th St</u>		



CERTIFICATE OF DEATH

REG. NO.

71 3507

BIRTH NO. 71-5214 71 3507

1. NAME OF DECEASED
(Type or Print)Jacqueline
BABY BOY RICHARD

2. DATE AND HOUR OF DEATH

4/3/71

5:17 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

825 N. FULTON AVE.

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3/30/71

9. AGE (in years
last birthday)

21

If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

0 4 30

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Maryland USA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Jacqueline Richards

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

BCH RECORDS: 4940 Eastern Avenue
Baltimore, Maryland 21224

18. 778.2 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

RESPIRATORY DISTRESS SYNDROME 15 MINS.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:PRENATALITY 0 MINS.
(B) DUE TO, OR AS A CONSEQUENCE OF:PULMONARY HEMORRHAGE 4 DAYS
(C) DUE TO, OR AS A CONSEQUENCE OF:II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
YES20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 30 1971 to April 3 1971
that (I) (we) last saw the deceased alive on 4/3 1971 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Peter O. Krutovich

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/3/71

23C. PHYSICIAN'S
NAME (Type)

Peter O. Krutovich, MD.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland
Baltimore City Hospital 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

4-5-71

24C. NAME OF CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION

(City, town, or county)

Baltimore, Maryland 21224

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 12 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

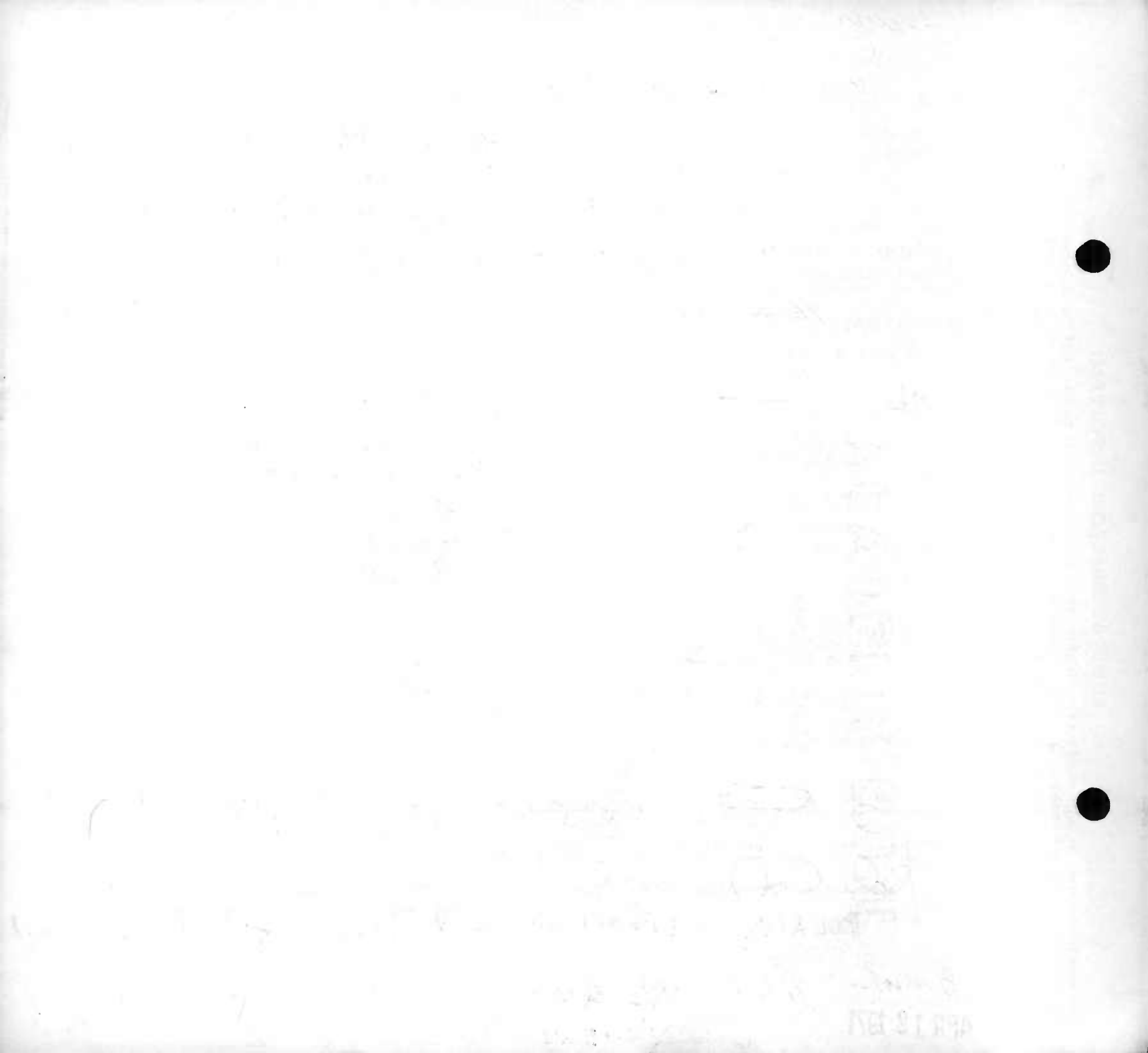
512



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

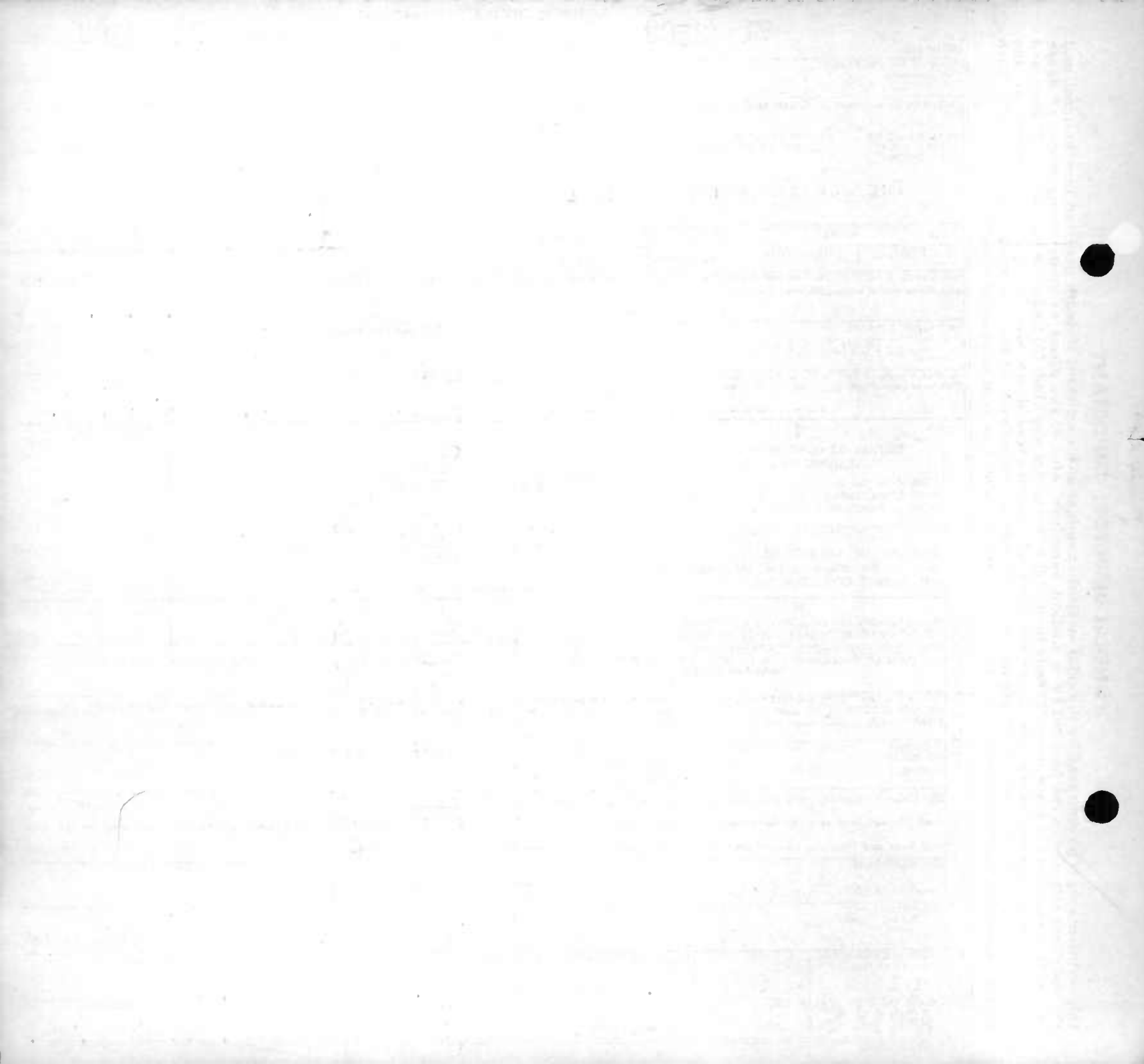
BIRTH NO. 71 3508				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3508			
1. NAME OF DECEASED (Type or Print) <u>Mary Goles (MARY GOLES)</u>				2. DATE AND HOUR OF DEATH <u>4.7.1971</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home & Hospital</u> <u>100 N. Broadway Balto MD 21231</u>				A. STATE <u>MD.</u>				B. COUNTY <u>Wahler Way (21224)</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>1229 Wahler Way 2636</u>							
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02 02-86</u>		9. AGE (in years last birthday) <u>85</u>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lepak</u>				14. MOTHER'S MAIDEN NAME <u>Annie Unknown</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214 24 2003</u>		17. INFORMANT <u>Josephine Ferro - 208 Ventnor Terrace</u>				ADDRESS	
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiogenic Shock</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASEVD</u> <u>Pneumonitis</u> <u>CVA Left side</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>April 1</u> 19 <u>71</u> to <u>April 7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Rolando Mendola</u>				23B. PHYSICIAN'S NAME (Type) <u>ROLANDO MENDOLA, MD.</u>		23C. ADDRESS <u>100 N. Broadway Balto MD. 21231</u>		23D. DATE SIGNED <u>4/7/71</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>4/9/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART JESUS</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>...</u>		25D. ADDRESS <u>...</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

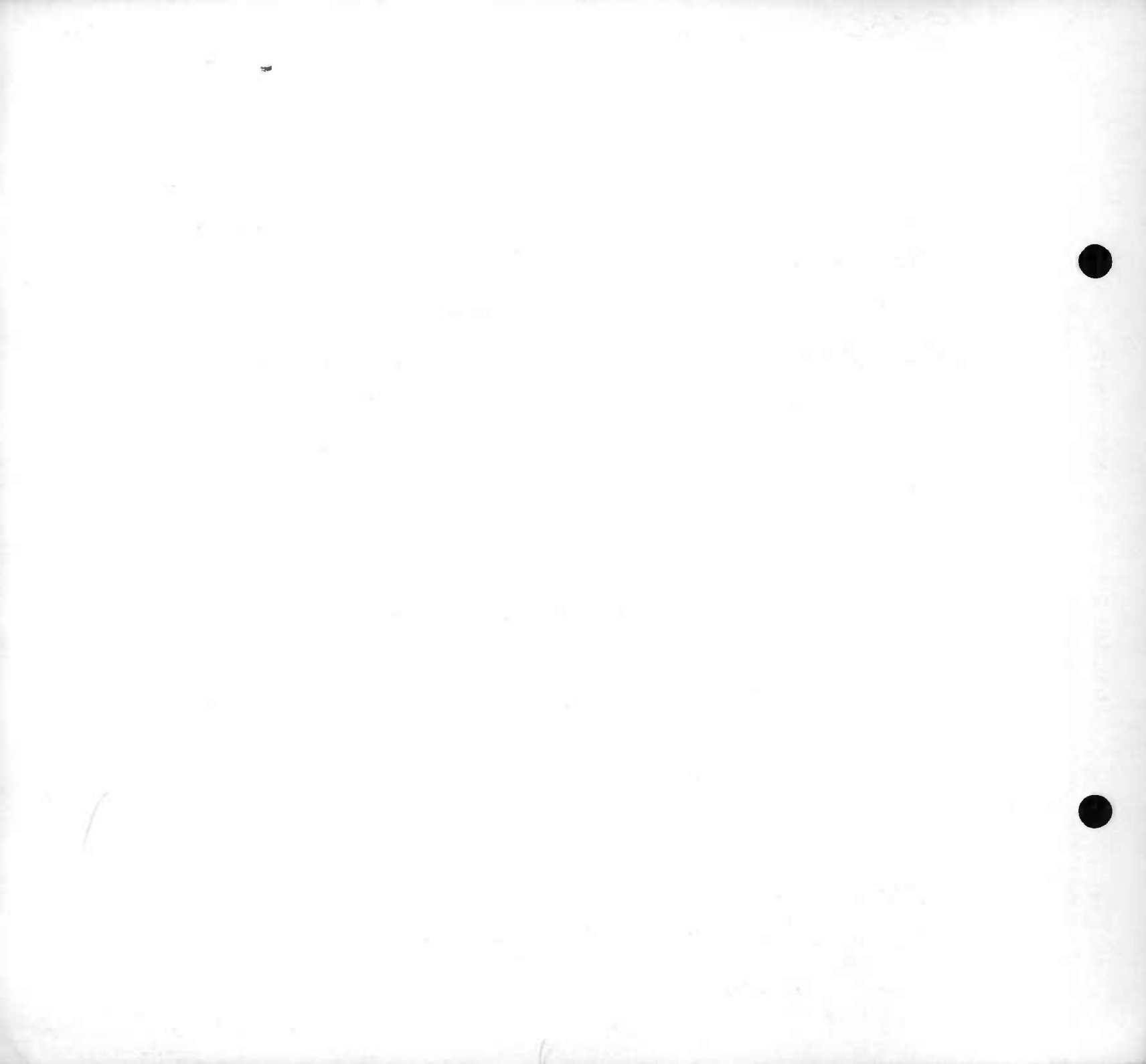
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3509	
W-252		71 3509		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) MARIE E WASHINGTON			2. DATE AND HOUR OF DEATH APRIL 5 1971 4:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 704		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 819 DALLAS ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-12	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME STEVEN BLUE		
14. MOTHER'S MAIDEN NAME SARAH DAWSON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-26-0739			17. INFORMANT Willard Washington, Baltimore, Md.		
18. 547.041 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). - DIABETES MELLITUS - R CEREBROVASCULAR ACCIDENT		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) March 2 1971 to April 5 1971		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? many years 5 weeks		
22. I certify that (1) (this hospital) attended the deceased from March 2 1971 to April 5 1971 and that (2) (we) last saw the deceased alive on April 5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Trexler M Topping MD			23B. DATE SIGNED 4/6/71		
23C. PHYSICIAN'S NAME (Type) Trexler M Topping MD			23D. ADDRESS Johns Hopkins Hospital, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/71		24C. NAME of CEMETERY or CREMATORY St. James Church Cem.	
24D. LOCATION (City, town, or county) (State) Bealeton, Virginia		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Md.	
25C. FUNERAL DIRECTOR Joynes Funeral Home, Warrenton, Va.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3510</u>	
BIRTH NO. <u>5-530 71 3510</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Smith, Miss Viola</u>		2. DATE AND HOUR OF DEATH <u>4-9-71</u> <u>1:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u> <u>Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>21223</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1532 EDMONSON AVENUE</u>	
5. SEX <u>Female</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/29</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>	9. AGE (in years last birthday) <u>41</u>
11. BIRTHPLACE (State or foreign country) <u>BALTE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE SMITH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>CHART</u>		ADDRESS	
18. <u>470.941303.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>= CHRONIC ALCOHOLISM</u> <u>= GRAND MAL SEIZURES POST-CRANIOTOMY</u>			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-8-</u> 19 <u>71</u> to <u>4-9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>OSCAR E. FERNANDINI M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>4-9-71</u>
23C. PHYSICIAN'S NAME (Type) <u>OSCAR E. FERNANDINI M.D.</u>		23D. ADDRESS <u>2025 W. FAYETTE ST. BALTO. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/14/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>MT ARCADE</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Monroe D. Long</u>
		ADDRESS <u>638 S. GILMAN ST</u>	



1

4630 71 3511 BALTIMORE CITY HEALTH DEPARTMENT 71 3511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) ROSA HAYWARD		2. DATE OF DEATH Known <input type="checkbox"/> Month _____ Day _____ Year _____ Hour _____ Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1210 Whitelock St		3. DATE PRONOUNCED DEAD Month _____ Day _____ Year _____ Hour _____ April 7, 1971 11:55 A.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 84		E. STREET AND NUMBER 1210 Whitelock Street	
11. BIRTHPLACE (State or foreign country) Precious Inn Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	
15. MOTHER'S MAIDEN NAME Harriett Smallwood		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 215-30-7076		18. INFORMANT Urges B. Ruggold 1463 D.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/8/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 11/71	
24C. NAME OF CEMETERY or CREMATORY Arbutus M. Park		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Gabley, M.D.	
25C. FUNERAL DIRECTOR V. Brooks Ruggold		ADDRESS 1463 D. Carey St	

VS 151-REV. 1/1/68

is a collection

of the

of the

of the

of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3512		71 3512	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Kelley Elizabeth</u>				2. DATE AND HOUR OF DEATH <u>April 2 1971 11h 10'A M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5307 Leith road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-26-17</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator switchboard</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u>		ADDRESS
18. <u>4309 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Subarachnoid Hemorrhage</u> (B) <u>Mild cerebral artery aneurysm.</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>03-22-1971</u> to <u>April 2 1971</u> that (I) (we) last saw the deceased alive on <u>April 2 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Tulio Bontorini</u>				23B. DATE SIGNED <u>April 2 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>TULIO BONTORINI</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/5/71</u>		24C. NAME of CEMETERY or CREMATORY <u>GLEN HAVEN</u>		24D. LOCATION (City, town, or county) (State) <u>RITCHIE HWY. BALTO. Md.</u>	
25A. DATE RECD BY HEALTH DEPT. <u>APR 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph D. Delp, D.F.</u>		ADDRESS <u>322 S. HIGH ST</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-600				71 3513		CERTIFICATE OF DEATH		REG. NO. 71 3513	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CAREY, HELEN		2. DATE AND HOUR OF DEATH 4/9/71 6:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 301					
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 221 S. Mosoy Court				21231 007					
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-21	9. AGE (In years last birthday) 50	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mac Kullerbrew				14. MOTHER'S MAIDEN NAME Hattie Hardy					
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. —		17. INFORMANT 4940 Eastern Avenue BCH-Records Baltimore, Md. 21224			
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) metastatic adenocarcinoma breast - 6 yrs. DUE TO, OR AS A CONSEQUENCE OF: (C) presumed cerebral metastases - 2nd				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION Feb 6, 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED breast - metastatic		20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) exploratory laparotomy		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 4/7 19 71 to 4/9 19 71 that (2) (we) last saw the deceased alive on 4/9 19 71 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael Jones MD				23B. DATE SIGNED 4/9/71					
23C. PHYSICIAN'S NAME (Type) MICHAEL JONES				23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph L. Lock		ADDRESS 1309 N. Central Ave			

100
200
300
400
500
600
700
800
900
1000

1000
900
800
700
600
500
400
300
200
100

X

1000
900
800
700
600
500
400
300
200
100

—

1000
900
800
700
600
500
400
300
200
100

1000
900
800
700
600
500
400
300
200
100

1000
900
800
700
600
500
400
300
200
100

1000
900
800
700
600
500
400
300
200
100

1000
900
800
700
600
500
400
300
200
100

1000
900
800
700
600
500
400
300
200
100

1000
900
800
700
600
500
400
300
200
100

W-426

71

3514

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

3514

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BILLIE WILKERSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00707 W. Lexington St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 16 1971 8:07 a.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 60		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 707 W. Lexington St.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 486x CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Pneumonia, right lung DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/16/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/1/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) D.A. County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.	
25C. FUNERAL DIRECTOR Sam F. Gault		ADDRESS 1712 W. North Ave	

10/1/72 L. J. J. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3515	
E-663 71 3515		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Minnie Ehrhardt	
2. DATE AND HOUR OF DEATH April 2, 1971 10³⁰ A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5806 Harford Rd		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Md 2706		A. STATE B. COUNTY	
C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5806 Harford Rd			
5. SEX F.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27 92
9. AGE (In years last birthday) 79		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Campeseggi		14. MOTHER'S MAIDEN NAME — E. Otis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mary E. Barbe		ADDRESS Same	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cons. Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to April 2nd 1971 , that (I) (we) last saw the deceased alive on March 31st 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="radio"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE Geo H. Beck		23B. DATE SIGNED 4/3/71	
23C. PHYSICIAN'S NAME (Type) GEORGE H. BECK		23D. ADDRESS HARFORD RD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/71	
24C. NAME OF CEMETERY or CREMATORY Moreland		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Galt	
25C. FUNERAL DIRECTOR Paul W. Gorman		ADDRESS 6067 Harford Rd	

Handwritten text at the top of the page, possibly a title or header.

Handwritten text in the upper middle section.

Handwritten text in the middle left section.

Handwritten text in the middle right section.

Handwritten text in the lower middle left section.

Handwritten text in the lower middle section.

Handwritten text in the lower right section.

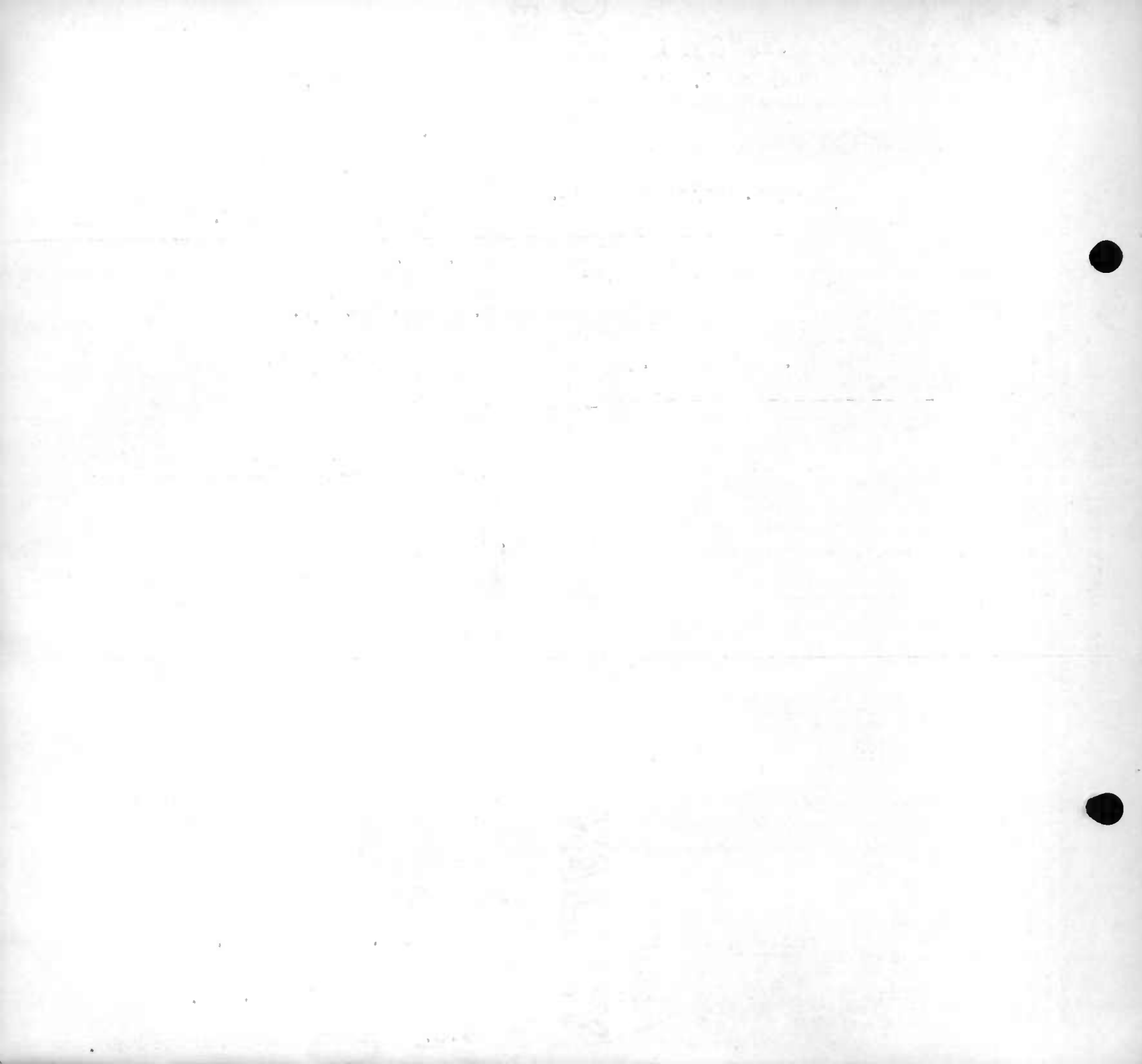
Handwritten text in the bottom right section.

Handwritten text in the bottom left section.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

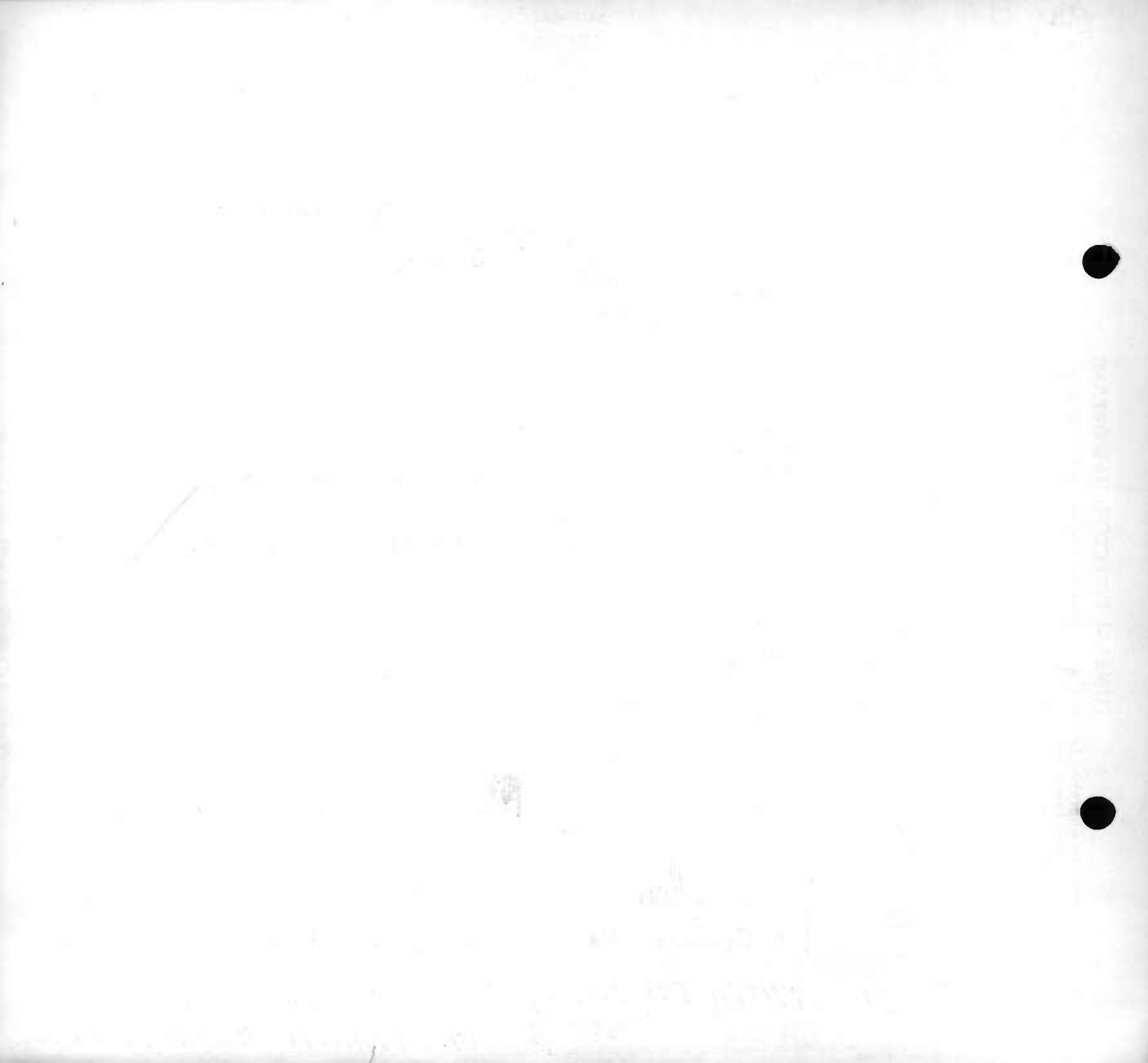
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3516	
S-530 71 3516 1. NAME OF DECEASED (Type or Print) Charles A. Smith		2. DATE AND HOUR OF DEATH March 31, 71 11:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2049 E. Belvedere Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2758 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2049 E Belvedere Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20.1900	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Maker		10B. KIND OF BUSINESS OR INDUSTRY American Meter Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Charles A. Smith Sr.			14. MOTHER'S MAIDEN NAME ? Jefferson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 216-09-4493		17. INFORMANT Wife	
18. 410-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 7 19 71 to 3-31 19 71 , that (I) (we) last saw the deceased alive on 3-4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis X Carmody				23B. DATE SIGNED 4-1-71	
23C. PHYSICIAN'S NAME (Type) Francis X Carmody		23D. ADDRESS 3201 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/71		24C. NAME OF CEMETERY or CREMATORY Moreland	
24D. LOCATION (City, town, or county) (State) Balto. Co.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR. Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR ADDRESS P.A. Heemahn 6067 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

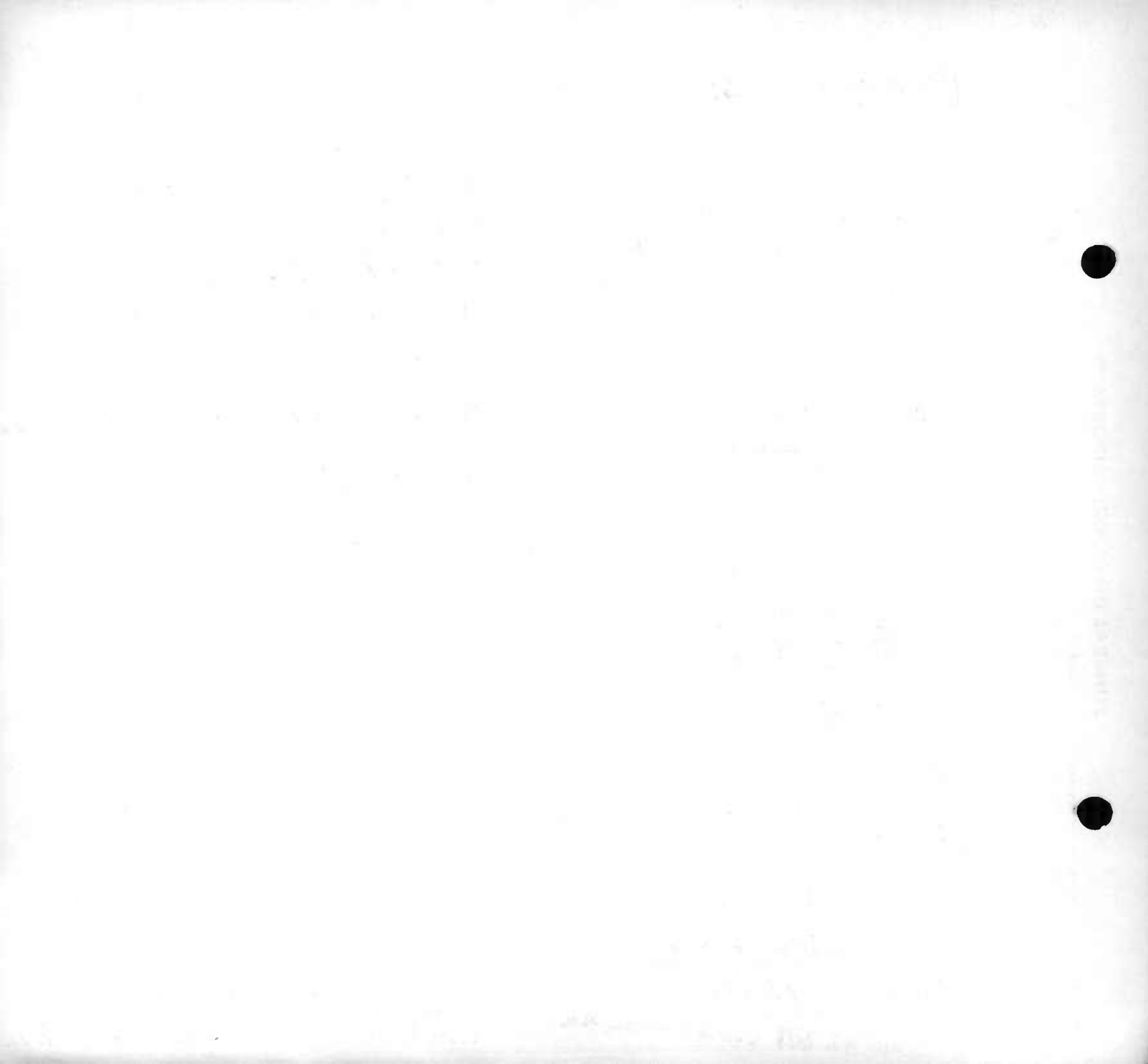
BALTIMORE CITY HEALTH DEPARTMENT									
71 3517					REG. NO. 71 3517				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) BARTEE WILLIAM					2. DATE AND HOUR OF DEATH 4.9.71 1:45 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Md.					A. STATE MD.				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY 1607				
					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 1501 DUKELAND ST.				
5. SEX m	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.3.10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY Unemployed			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Chart				ADDRESS
18. 11.942150.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE Cachexia and debility. DUE TO, OR AS A CONSEQUENCE OF: (B) Chr Tuberculosis and diabetes DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4.6.1971 to 4.9.1971 that (I) (we) last saw the deceased alive on 4.8.1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Govinda Rao					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4.9.71	
23C. PHYSICIAN'S NAME (Type) R. GOVINDA RAO					23D. ADDRESS LUTHERAN HOSPITAL of MARYLAND.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/15/71			24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem			24D. LOCATION (City, town, or county) (State) Anne Arundel Cty. Md
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			25B. NAME OF REGISTRAR Robert E. Searcy, M.D.			25C. FUNERAL DIRECTOR W. E. March			ADDRESS 928 E. North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

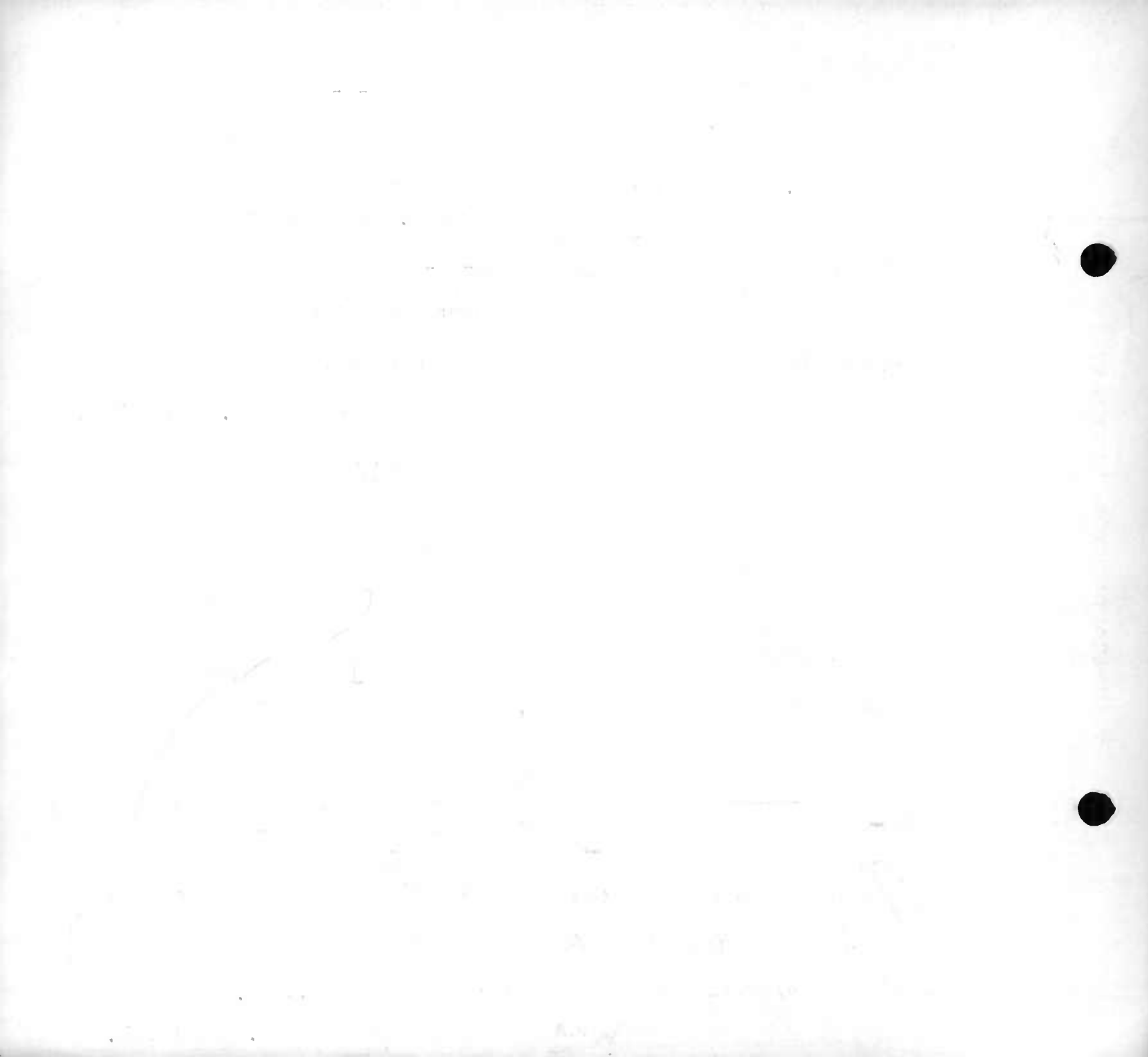
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3518</u>	
BIRTH NO. <u>71 3518</u>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
(BOWLES) BOULDS, ULLMAN W.			4.7.71 at 8am A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSP OF MARYLAND			A. STATE Maryland B. COUNTY 1608		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 609 Lynhurst St.		
5. SEX M	6. RACE NEgro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-97	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Elmore			14. MOTHER'S MAIDEN NAME Louisa Bowles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 227-14-4259		17. INFORMANT Miss ALTON BOWLES 609 LYNHURST ST
18. 197.8 I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE INTESTINAL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CA LIVER DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from 4.7.1971 1:50pm to 4.7.1971 8am and that (ii) (we) lost saw the deceased alive on 4.7.1971 at 8am and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John A. Arain M.D.				23B. DATE SIGNED 4.7.1971	
23C. PHYSICIAN'S NAME (Type) JOHN A. ARAIN M.D.				23D. ADDRESS LUTHERAN HOSP OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 4/11/71		24C. NAME of CEMETERY or CREMATORY FAIRFAX COUNTY VA.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Wm C. March 928 E. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3519	
CERTIFICATE OF DEATH					
BIRTH NO. 71 3519		1. NAME OF DECEASED (Type or Print) SALLIE MILLER			
2. DATE AND HOUR OF DEATH 4-5-71		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 908		5. SEX Female 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-17-22 9. AGE (In years last birthday) 48			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 704 E. 20th Street		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME George Johnson		14. MOTHER'S MAIDEN NAME Maggie Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mary Cleveland 704 E. 20th Street	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: H.C.U.D. (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 1969 to March 1971 that (I) (we) lost saw the deceased alive on March 30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jesse T. Holmes M.D.				23B. DATE SIGNED 4/12/71	
23C. PHYSICIAN'S NAME (Type) Jesse T. Holmes M.D.		23D. ADDRESS 508 E. NORTH AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) Balto., Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3520	
BIRTH NO. 71-18557 Robinson		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robinson, William Edward		2. DATE AND HOUR OF DEATH 4.8.71 7:50 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland		A. STATE Baltimore		B. COUNTY 1901	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 816 N. Cony St. #23					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.17.40	9. AGE (In years last birthday) 5 months	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Lutheran Hosp., Balt	
12. CITIZEN OF WHAT COUNTRY American		13. FATHER'S NAME William Robinson			
14. MOTHER'S MAIDEN NAME Rennie Bridgman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT William Robinson 316-N. Carey St			
18. 246.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Endocarditis arrest			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Cong. heart disease C.O. since birth			
		(C) DUE TO, OR AS A CONSEQUENCE OF: (1) Foreign birth (2) Injurious hereditary (3) Chylothorax 2 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 13.39.71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cong. heart dis		20A. AUTOPSY? (Yes) <input checked="" type="checkbox"/> (No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3.15.1971 to 4.8.1971 that (I) (we) last saw the deceased alive on 4.8.71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Yuzadek Vorobin M.D.		23B. DATE SIGNED 4.8.71		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-71		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.	
24D. LOCATION Baltimore, Md. 21		24E. DATE REC'D BY HEALTH DEPT. APR 12 1971			
24F. NAME OF REGISTRAR E. J. Taylor, Md.		24G. FUNERAL DIRECTOR Morton Dyett F.H.		24H. ADDRESS 1701-Hawkins St	



1
D152

BALTIMORE CITY HEALTH DEPARTMENT

71 3521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3521

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH DUPPINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year April 7, 1971		Hour 3:41 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year April 7, 1971		Hour 3:41 P.M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH June 26, 1913		10. AGE (In years lost birthday) 57		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Harry Duppins		14. MOTHER'S MAIDEN NAME Isabella Duppins
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-18-6607
18. INFORMANT Earl Carroll		19. ADDRESS 2702 Hillside Rd.		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) _____ (C) _____		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. DATE OF OPERATION 4-12-71		26. CONDITION FOR WHICH OPERATION WAS PERFORMED
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 4-12-71		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?
33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL EXAMINER'S SIGNATURE Ronald N. Kornblum, M.D.		35. DATE SIGNED 4/8/71
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		38. LOCATION (City, town, or county) (State) Baltimore, Maryland
39. DATE REC'D BY HEALTH DEPT. APR 12 1971		40. NAME OF REGISTRAR John E. Taylor, M.D.		41. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens Street

at a cost of \$1,700 per acre

about 1000

10-10-70

10-10-70

WALTER H. DAVIS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BRUCE R. HARPER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 9 1971 9:40 a.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Nov. 9, 1949		10. AGE (In years lost birth day) 21	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME India Harper	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-52-0721	
18. INFORMANT Richard Harper		ADDRESS 2042 Walbrook Ave.	
19. E966X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stab wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) apartment	
22C. WHERE DID INJURY OCCUR? 131 N. Aisquith St. Apt. 7		22F. HOW DID INJURY OCCUR? Stabbed by wife.	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4-9-71 9:10 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

WALTER D. BROWN

Nov. 1901
Richard Brown
In the
Richard Brown
Nov. 1901

Nov. 1901
Richard Brown
In the
Richard Brown
Nov. 1901

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3523</u>	
BIRTH NO. <u>71 3523</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Beatrice Jones</u>			2. DATE AND HOUR OF DEATH <u>4/8/71</u> <u>10:00</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE <u>Maryland</u>		
			B. COUNTY <u>Baltimore</u>		
5. SEX <u>F</u>			6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <u>02-24-21</u>			9. AGE (In years last birthday) <u>50</u>		10. UNDER 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Edgecombe City, N C</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Allen Jones</u>		
14. MOTHER'S MAIDEN NAME <u>Almeta Kane</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Gertrude Green</u> ADDRESS <u>4502 Groveland Ave</u>		
18. <u>174X I</u>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular arrest</u>		
ANTECEDENT CAUSES			(B) <u>Widespread metastatic breast Ca</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2 yrs.</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> 19 <u>71</u> to <u>4/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter Densen</u>			23B. DATE SIGNED <u>4/9/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Peter Densen MD</u>			23D. ADDRESS <u>601 N Broadway, Balto. Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-12-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Wilson Cemetery</u>	
24D. LOCATION <u>Tarbaro, N C</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F H Baltimore Md 21217</u>			

2

2

2

1911

1911

1911

1911

1911

1911

1911

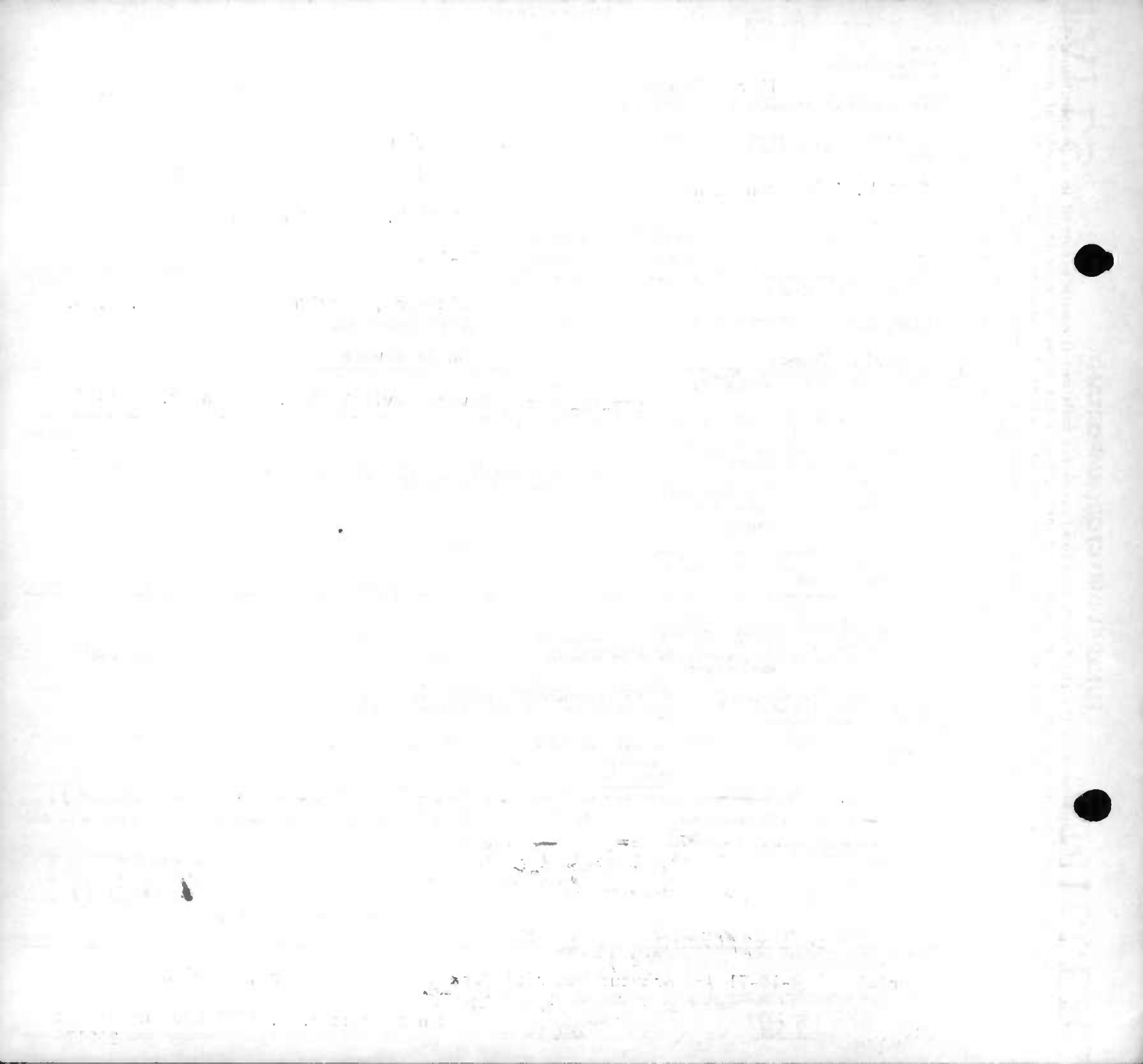
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 3524

BIRTH NO. 71 3524		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3524	
1. NAME OF DECEASED (Type or Print) Mildred Thomas			2. DATE AND HOUR OF DEATH 7 April 1971 10:30 am.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 2522 W. Coldspring Lane			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F			6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 11-17-1904			9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles Thomas			14. MOTHER'S MAIDEN NAME Annie Bowers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-14-9485		17. INFORMANT Edward Davis 2000 N. Payson St. 21217
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 27 Sept 1962 to 7 April 1971 that (I) (we) last saw the deceased alive on 19 Feb 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles R. Davidson M.D.			23B. DATE SIGNED 8 April 71		23C. PHYSICIAN'S NAME (Type) Charles R. Davidson M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-10-71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens Street 21217



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3525	
BIRTH NO. 13635 71 3525				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Stanislaus Bartynski			2. DATE AND HOUR OF DEATH April 8-1971 3:05 P.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Md. 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 233 S. Madiera St. 21224 007		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-92	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Walter Bartynski			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No			14. MOTHER'S MAIDEN NAME Sophia Szwed		
16. SOCIAL SECURITY NO. 216-07-9762			17. INFORMANT BCH-Records		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION NONE 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.) 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. TIME OF INJURY (Month) (Day) (Year) (Hour) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. DATE SIGNED 4-8-71			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR 3 WKS years		
22. I certify that (I) (this hospital) attended the deceased from 3/5 19 71 to 4/8 3:05 PM 19 71 that (I) (we) last saw the deceased alive on 4/8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. S. Alfredsen			23B. DATE SIGNED 4-8-71		
23C. PHYSICIAN'S NAME (Type) K. S. Alfredsen			23D. ADDRESS 4940 Eastern Avenue BCH- Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 12 1971			
24F. NAME OF REGISTRAR George A. Weber		24G. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231			

Johnny's

24

N 620

71 3526

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3526

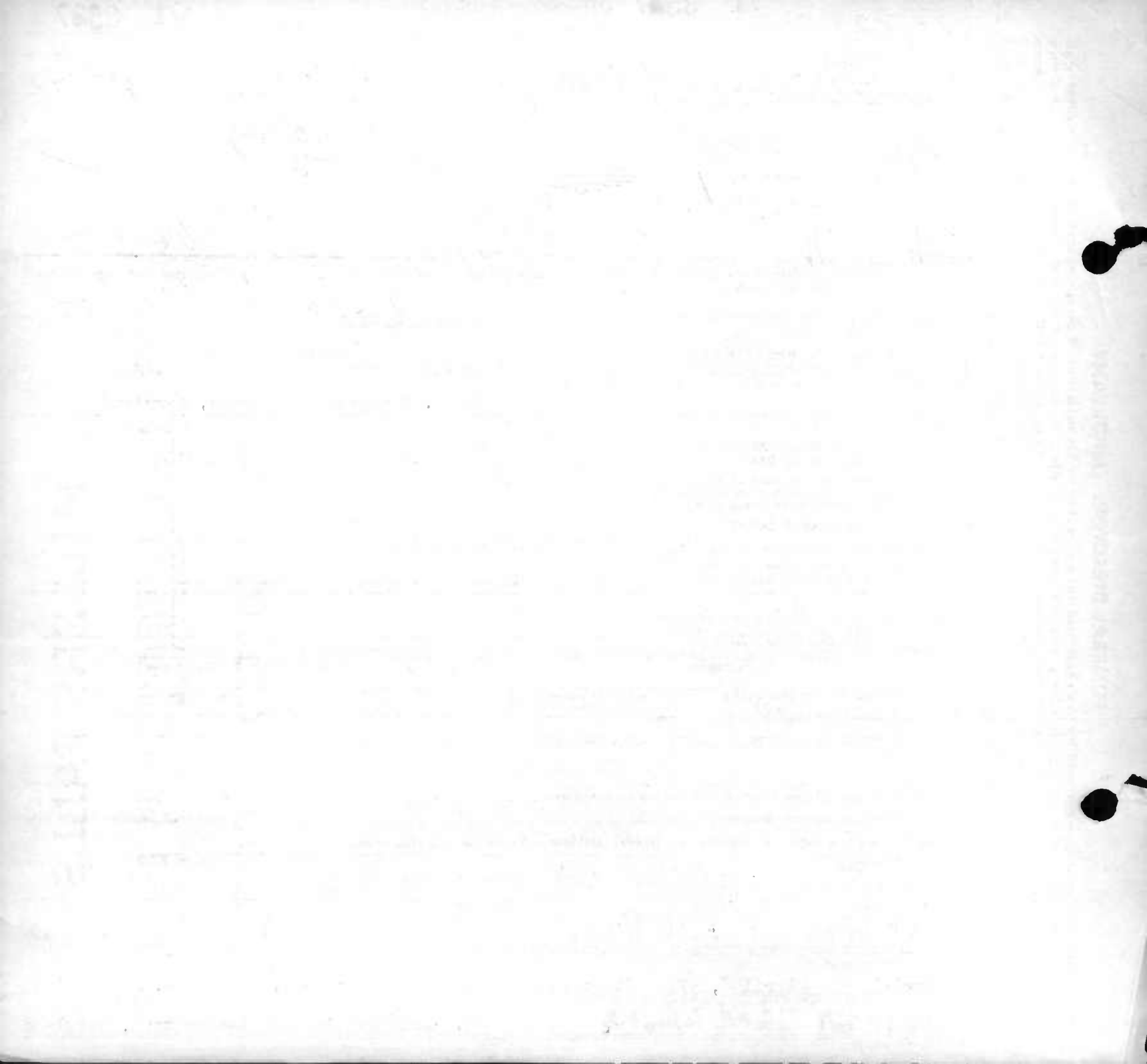
BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES MORRIS Norris		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 8 1971 7:15 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sept. 12, 1923		10. AGE (In years last birthday) 47	
11. BIRTHPLACE (State or foreign country) Gaffney S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storage		15. MOTHER'S MAIDEN NAME Floydia Norris	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Eva Lockhart		ADDRESS 40377 Cedardale Rd.	
19. CAUSE OF DEATH 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/9/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

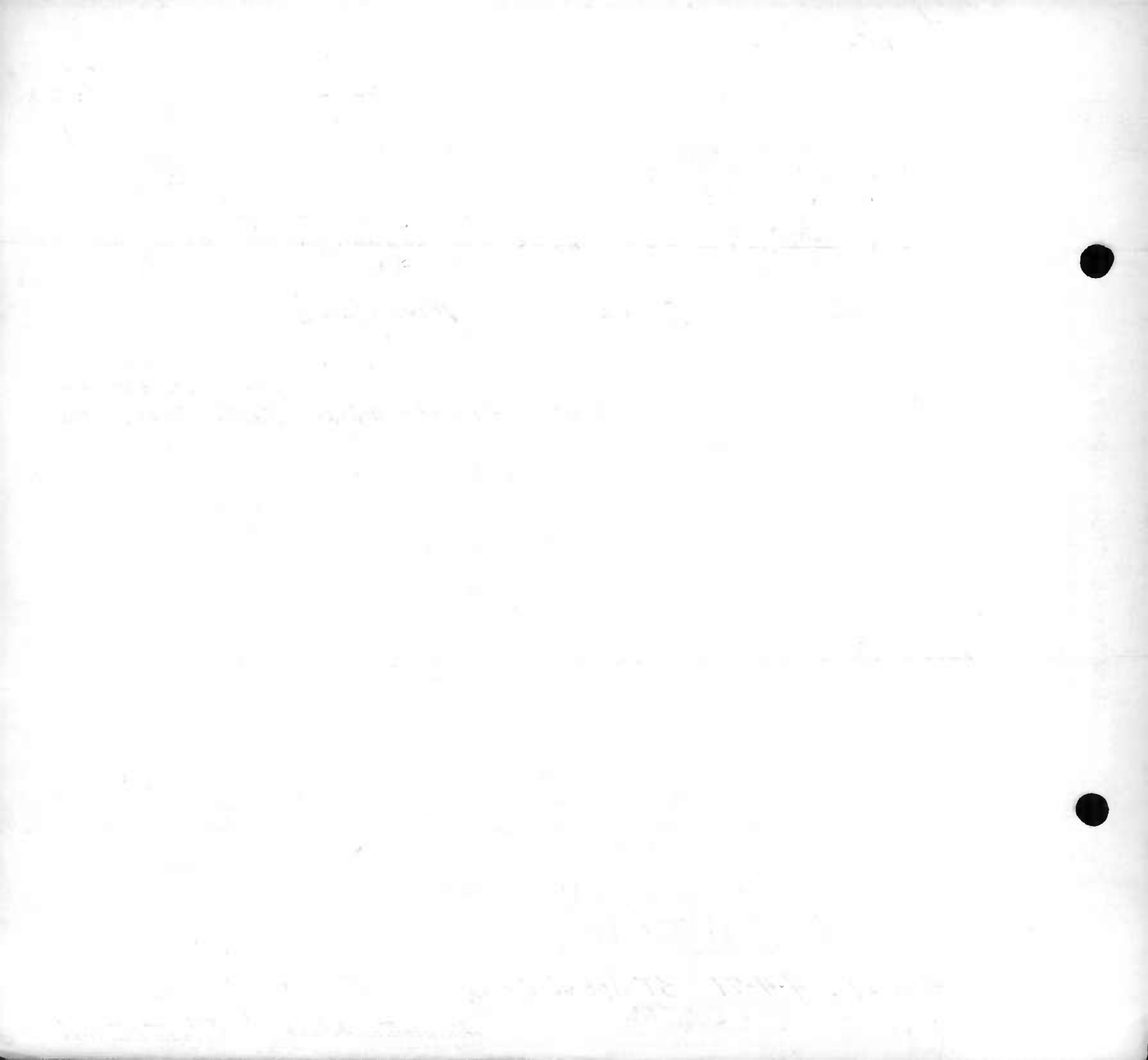
T-512		BALTIMORE CITY HEALTH DEPARTMENT		71 3527	
BIRTH NO.		CERTIFICATE OF DEATH		X REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Thompson, Mary</i>		2. DATE AND HOUR OF DEATH <i>4/5/71 1050 A.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>6800</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hosp. Broadway</i>		C. CITY OR TOWN <i>Clements</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>General Delivery</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/18/31</i>	9. AGE (In years last birthday) <i>39</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Carroll Holt</i>		14. MOTHER'S MAIDEN NAME <i>Rosalie Dorsey</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John H. Thompson</i> ADDRESS <i>Clements, Maryland</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>183.0 I Ovarian Carcinoma</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ovarian Carcinoma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/24/71</i> 19 <i>71</i> to <i>4/5</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4/5</i> 19 <i>71</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John Rampone, MD</i>		23B. DATE SIGNED <i>4/5/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>John Rampone</i>		23D. ADDRESS <i>Johns Hopkins Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>April 8, 1971</i>		24C. NAME OF CEMETERY or CREMATORY <i>St Josephs</i>	
24D. LOCATION <i>Morganza, St Mary's, Maryland</i>		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 12 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i> ADDRESS <i>Leonardtwn, Maryland</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3528			
H-322 71 3528				REG. NO. 71 3528			
BIRTH NO. <u>Balto. Co. Md.</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ANDREW SCOTT HODGES</u>				2. DATE AND HOUR OF DEATH <u>04-03-71</u> <u>10:10 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>1401</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>124 W. LAFAYETTE AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-01-71</u>		9. AGE (In years last birthday) <u>1</u> <u>2</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SNOWDEN HODGES</u>				14. MOTHER'S MAIDEN NAME <u>MARY PHELPS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Snowden Hodges</u> <u>124 W. LAFAYETTE AVE</u> <u>BALTO, 21217, MD</u>			
18. <u>747.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intracerebral hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
				(B) <u>Coarctation of aorta</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 month</u>			
				(C) <u>Hypertension</u>			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 30 1971</u> to <u>April 3 1971</u> that (I) (we) last saw the deceased alive on <u>April 3 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Paul A. Shurin MD</u>				23B. DATE SIGNED <u>4/3/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Paul A. Shurin</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-4-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. John's Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Higginbotham-Slack</u>		ADDRESS <u>Ellicott City, Md.</u>	

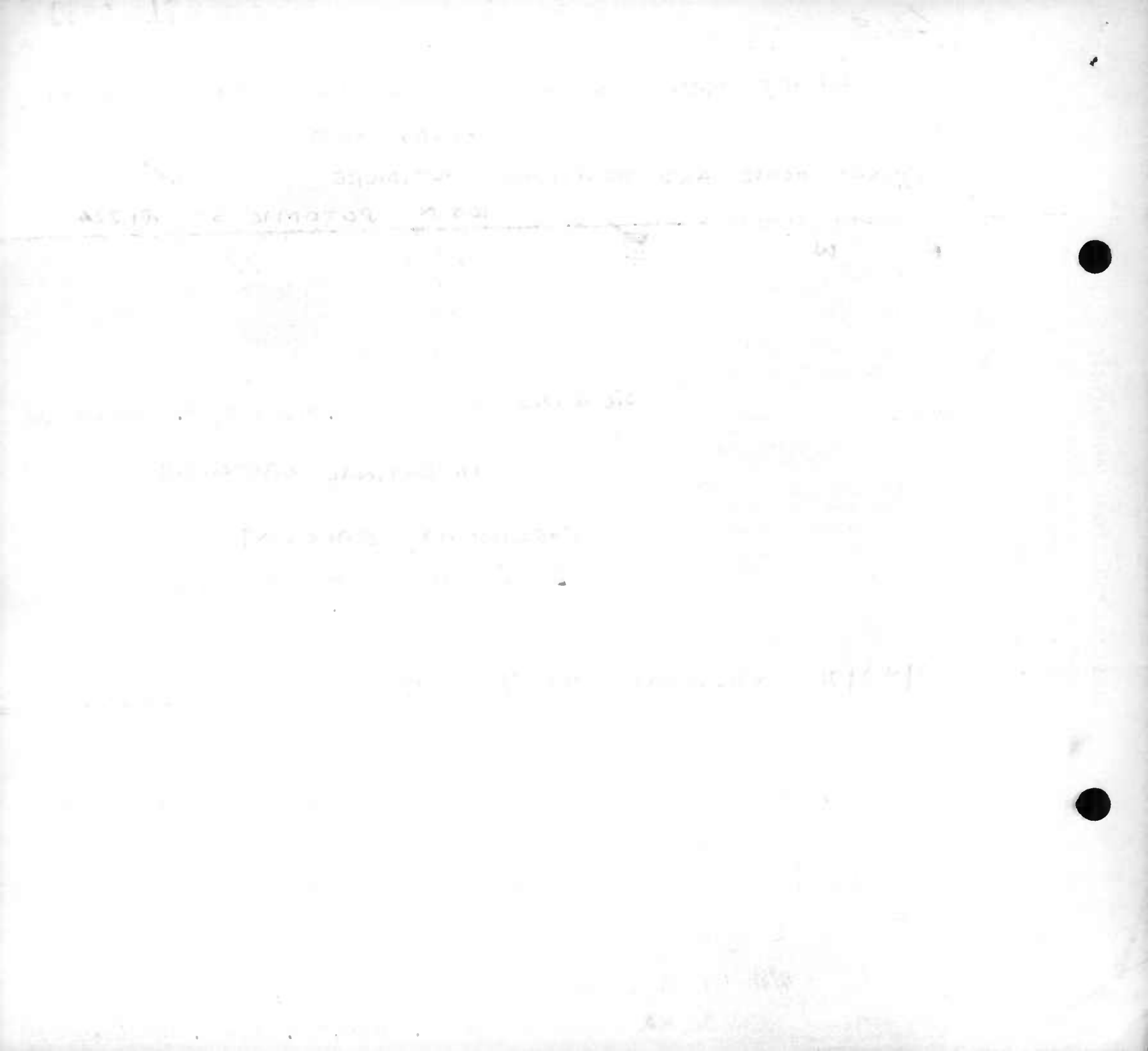


1		71 3529		BALTIMORE CITY HEALTH DEPARTMENT		X	
Y-520		71 3529		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 3529	
1. NAME OF DECEASED (Type or Print) Walter Young				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 5 71 8:54 p. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BA 5200				C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER Box 92			
9. DATE OF BIRTH 9/22/1935		10. AGE (In years last birthday) 35		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George F. Young		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		15. MOTHER'S MAIDEN NAME Anna V. Ladna		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. 214-38-9360		18. INFORMANT Charles J. Young		19. CAUSE OF DEATH E 8/13.6 I		20. ADDRESS As Above	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE Craniocerebral injury DUE TO, OR AS A CONSEQUENCE OF:			
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Jumpers Hole Rd. nr. Early Heights Rd.			
22D. TIME OF INJURY (APPROX.) 4 4 71 8:22 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? operator of bicycle in auto-bicycle collision.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		Deputy Chief Medical Examiner		DATE SIGNED 4/6/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/1971		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Walter E. Spitz		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

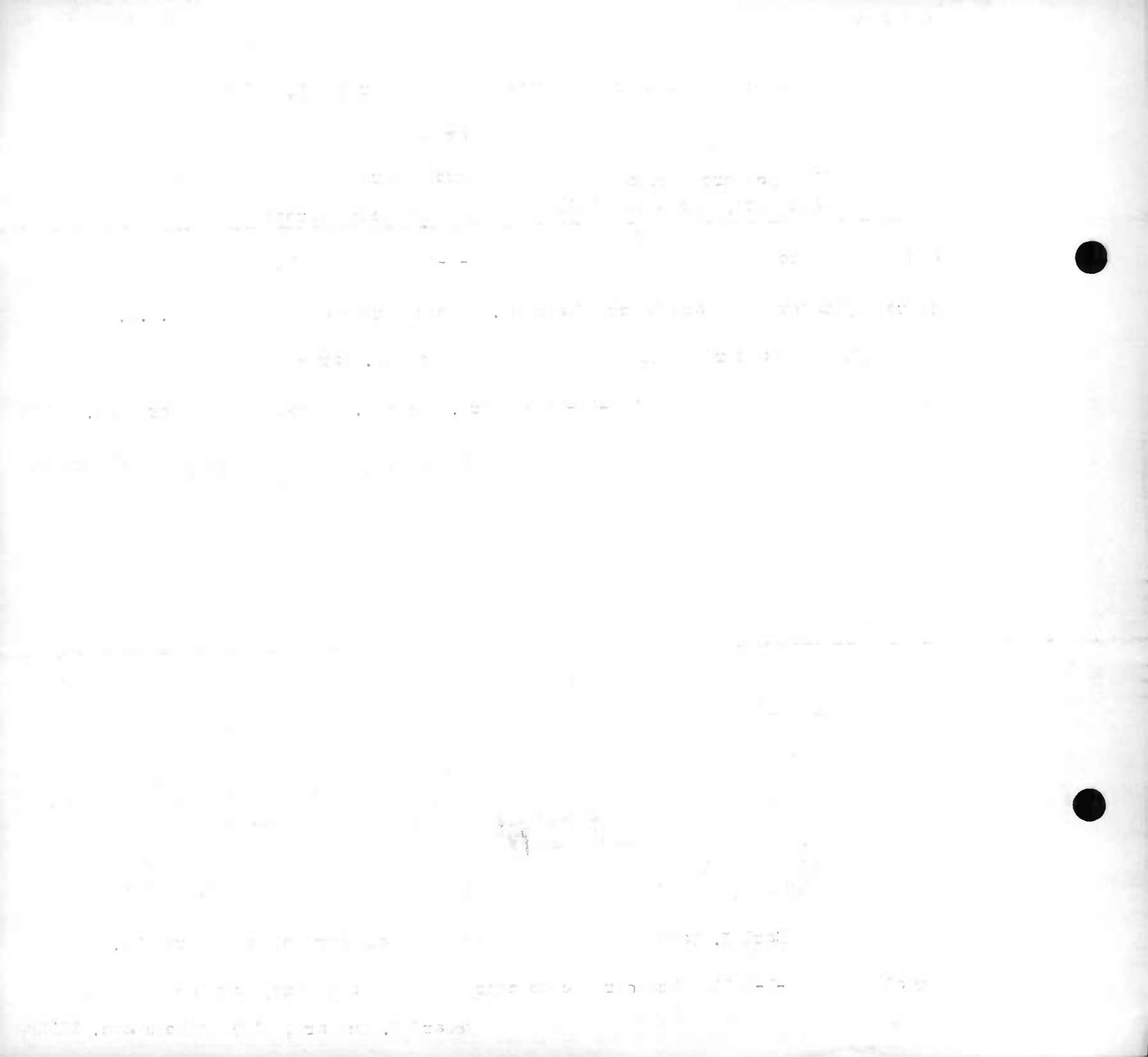
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
K-613 71 3530		71 3530		71 3530	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KRAFT MRS ANNA Marie		APRIL 5TH 1971		6:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
CHURCH HOME AND HOSPITAL		MARYLAND		601	
35		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		105 N POTOMAC ST		21224	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8/19/23	77	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Dombrowski		Louise Ostrowski		United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216 16 5262		Miss Dorothy M. Kraft 105 N. Potomac St	
18. 153.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		INTESTINAL OBSTRUCTION	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) CARCINOMA CAECUM			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Leak around Gastrostomy tube			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
13/23/71		CARCINOMA CAECUM		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-19-71 to 4-5-71 and that (I) (we) lost saw the deceased alive on 4-5-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Prabir K. Bose M.D.				4-5-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PRABIR K. BOSE M.D.		Church Home and Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/10/71		Holy Redeemer Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 12 1971		Prabir E. Bose, M.D.		John A. Moran, Inc. 3000 E. Baltimore St	



FUNERAL DIRECTOR: IMPORTANT

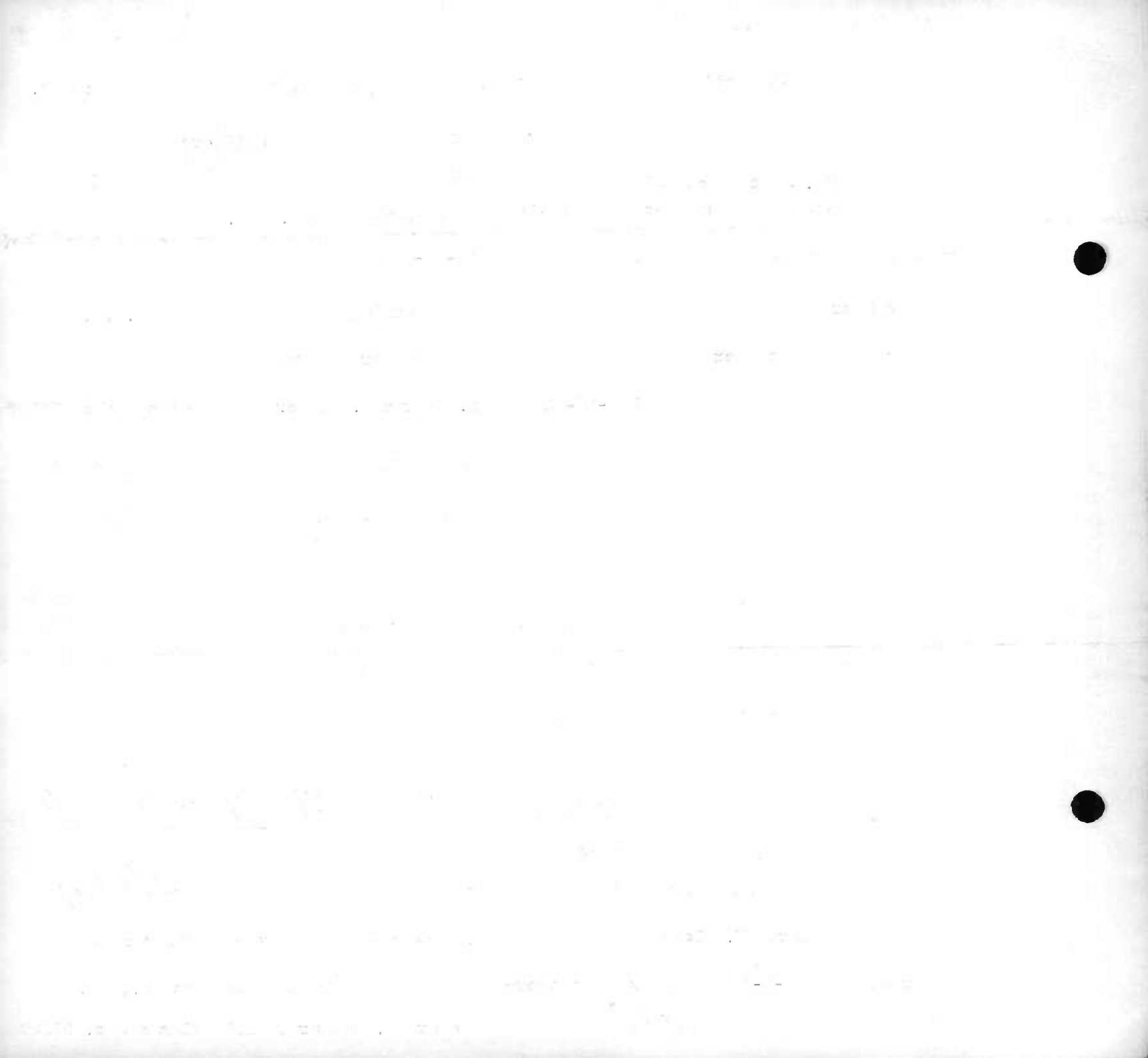
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____
W-300		71 3581	71 3581	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) HENRY ERNEST WHITE		
2. DATE AND HOUR OF DEATH April 3, 1971		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2553		
FULL NAME OF HOSPITAL OR INSTITUTION 00. 1708 Monterey Street Baltimore, Maryland 21230		C. CITY OR TOWN Morrell Park		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-1-1971		9. AGE (In years last birthday) 71		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator		10B. KIND OF BUSINESS OR INDUSTRY Carr Lowery Glass Co.		11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred Walter White		
14. MOTHER'S MAIDEN NAME Emma V. Harmon		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-10-6117		17. INFORMANT Mrs. Elsie H. White, 1708 Monterey St. 21230		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 6 mos.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/2 1970 to April 3 1971 that (I) was lost saw the deceased alive on April 2 1971 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.				
23A. SIGNATURE Earl I. Pass		23B. DATE SIGNED 4/5/71		23C. PHYSICIAN'S NAME (Type) Earl I. Pass
23D. ADDRESS 4001 Wilkens Avenue, Baltimore, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4-7-1971		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3532	
BIRTH NO. 11-460		31 3532		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		ELIZABETH MILLER		2. DATE AND HOUR OF DEATH April 4, 1971 2:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenues 21229		A. STATE Maryland B. COUNTY Baltimore 5300			
C. CITY OR TOWN Arbutus		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 4744 Westland Blvd. Apt. D					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-1882	9. AGE (In years last birthday) 88	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Kestler		14. MOTHER'S MAIDEN NAME Katherine Franz	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-22-1194D		17. INFORMANT ADDRESS Mr. George M. Miller, 3611 Durley Lane 21207	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute MI DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mins ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/29/71 to 4/4/71 that (I) last saw the deceased alive on 3/29/71 and that in my opinion death occurred on the date and hour and from the cause stated above, (I) (We) (did not) view the body after death.					
23A. SIGNATURE Earl I. Pass		23B. DATE SIGNED 4/5/71		23C. PHYSICIAN'S NAME (Type) Earl I. Pass	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-1971		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Baltimore Co., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3533	
1. NAME OF DECEASED (Type or Print) NELSON JOSEPHINE B. NELSON		2. DATE AND HOUR OF DEATH 4/8/71 9 45 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 203 S. Highland Avenue			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-94	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Hartman			14. MOTHER'S MAIDEN NAME Barbara Leimkuhler		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Gertrude Grymes 203 S. Highland Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: suspected acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic cardiovascular dis. (C) intestinal obstruction		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 14-8-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED attempted explor. lap		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-5-71 19 4-8 19 71 that (I) (we) last saw the deceased alive on 4-8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Villagarcia				23B. DATE SIGNED 4-8-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-1971		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



1

71 3534

BALTIMORE CITY HEALTH DEPARTMENT

W. 635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

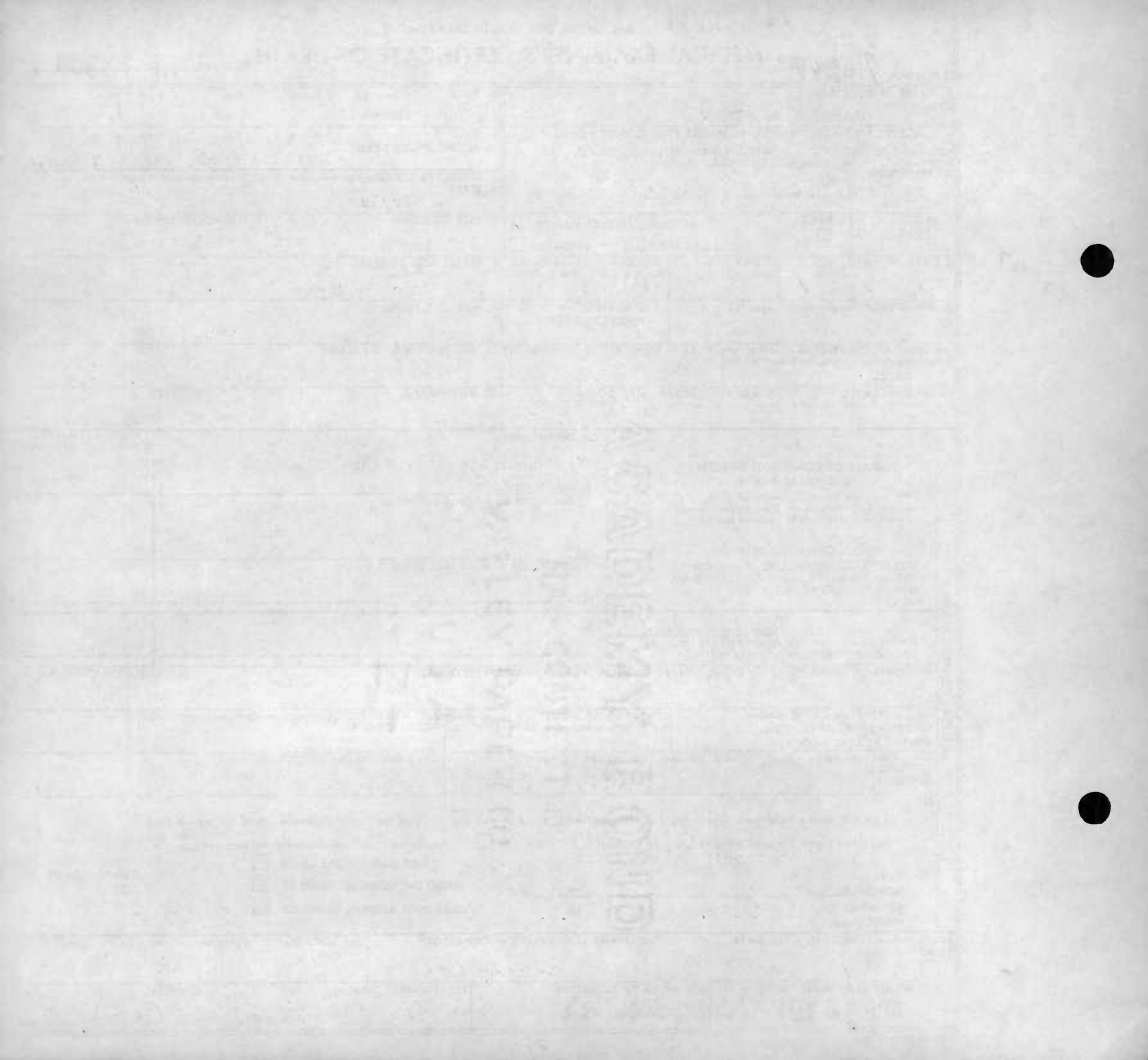
BIRTH NO. 710247

REG. NO. 71 3534

1. NAME OF DECEASED (Type or Print) JAMES WORTHAN		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 7, 1971 9:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 7, 1971 9:30 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-7-71		10. AGE (In years lost birthday) 2	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Gloria Christian		ADDRESS 922 N. Washington	
19. 795X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy		CAUSE OF DEATH Sudden death in infancy	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-9-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
		25C. FUNERAL DIRECTOR Charles L. H. 11297 Caroline St.	

DATE SIGNED
4/7/71

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

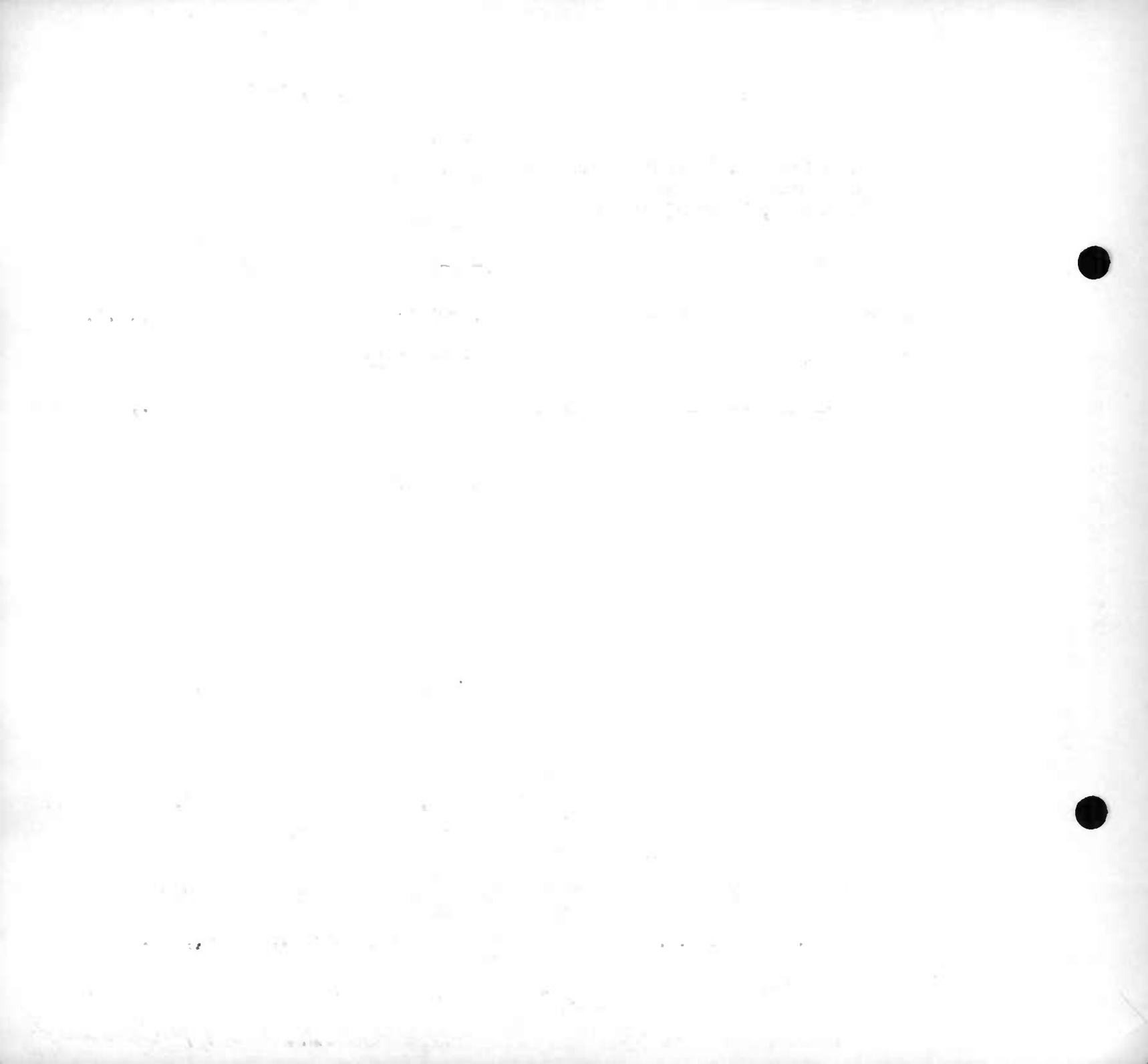
<div style="display: flex; justify-content: space-between;"> C-652 71 3535 BALTIMORE CITY HEALTH DEPARTMENT 71 3535 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 71 3535	
1. NAME OF DECEASED (Type or Print) CARRINGTON, BERNARD		2. DATE AND HOUR OF DEATH 4/8/71 12:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND 22 S. GREENE ST.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 284 S. SPRING CT.	
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/52 9. AGE (in years last birthday) 18 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BERNARD		14. MOTHER'S MAIDEN NAME LAURA VENABLE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. CHART	
17. INFORMANT ADDRESS			
18. 381.9 I CAUSE OF DEATH CENTRAL NERVOUS SYSTEM DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE COLLAPSE DUE TO, OR AS A CONSEQUENCE OF: PYOGENIC MENINGITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. LEFT OTITIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 7 DAYS 2 WEEKS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes) or No No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/2 19 71 to 4/8 19 71 that (I) (we) last saw the deceased alive on 4/7 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James Allen MD		23B. DATE SIGNED 4/8/71	
23C. PHYSICIAN'S NAME (Type) JAMES ALLAN MD		23D. ADDRESS 22 S. GREENE ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-71	
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR L. L. H. F. H. 11297 Caroline St.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

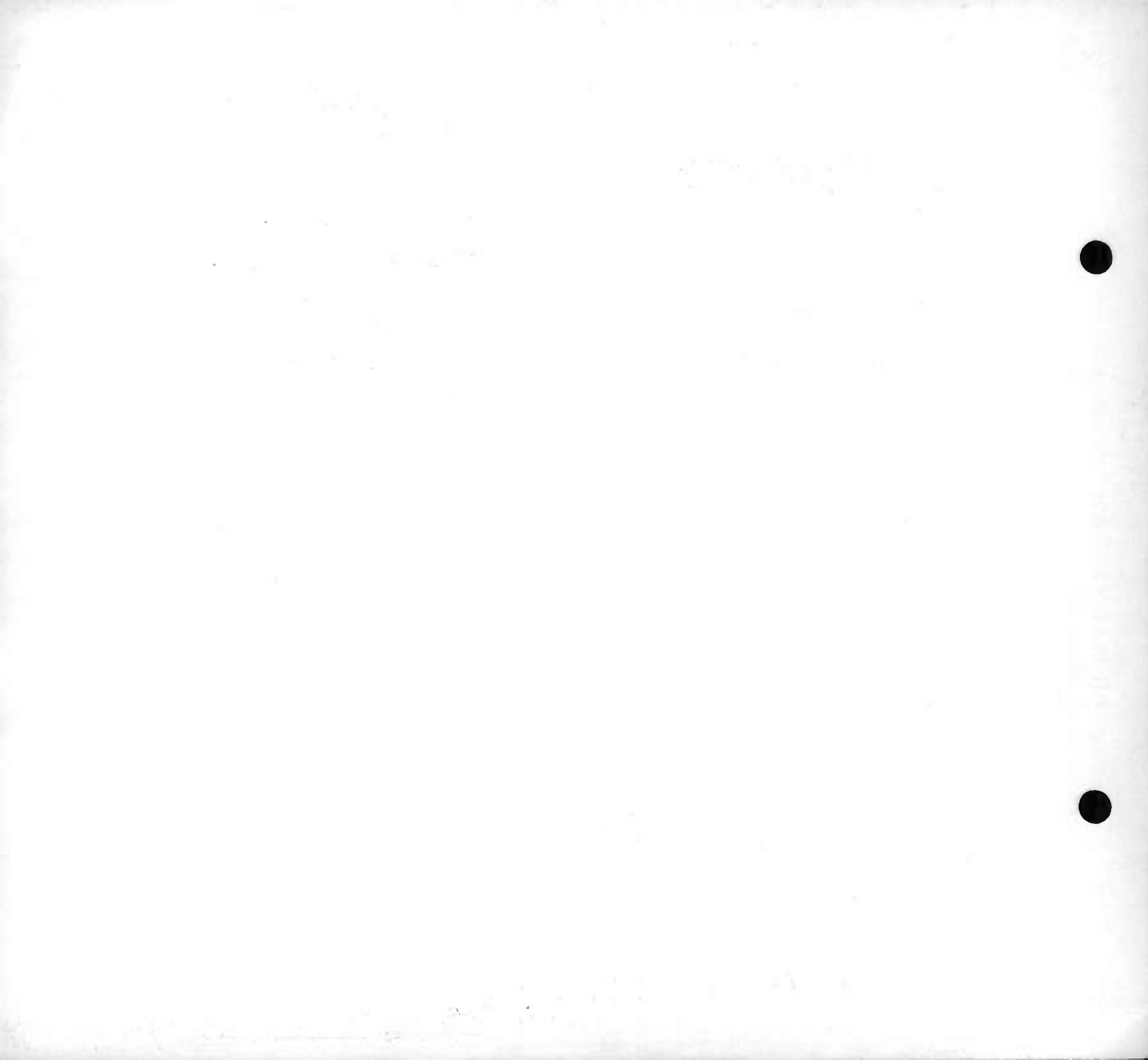
BALTIMORE CITY HEALTH DEPARTMENT				71 3536	
CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) LAMBERT, John Leroy				2. DATE AND HOUR OF DEATH April 8, 1971 7:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 313 Sharp Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-24-18	9. AGE (in years last birthday) 52	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ellis Lambert			
14. MOTHER'S MAIDEN NAME Rosie Blair		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-13-45 to 11-15-46			
16. SOCIAL SECURITY NO. 218-18-0799		17. INFORMANT Records ADDRESS VAH, 3900 Loch Raven Blvd Balto., Md 21218			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration pneumonia 2 weeks					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Alcoholism weeks Old AFBW LUL factory					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from April 8, 1971 to April 8, 1971 that (X) (we) last saw the deceased alive on April 8, 1971 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE M. Troner				23B. DATE SIGNED 4/9/71	
23C. PHYSICIAN'S NAME (Type) M. TRONER, M.D.				23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles H. 11297 P. Carver			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		71 3537	BALTIMORE CITY HEALTH DEPARTMENT		71 3537
BIRTH NO.			REG. NO.		
1. NAME OF DECEASED (Type or Print) Ann Graham (Hughes)			2. DATE AND HOUR OF DEATH 4/6/71 7:45		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Samaritan Hospital 1500 Loch Raven Boulevard Baltimore, Maryland 21239 45			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 704		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 918 McDonough St.		
5. SEX F	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/27	9. AGE (in years last birthday) 44 yrs.	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Alfred Hughes		
14. MOTHER'S MAIDEN NAME Mary Lynch			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Dave Graham-918 McDonough St.		
18. 734.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arrhythmia 20 (B) Systemic lupus erythematosus 17 yrs (C) Cerebrovascular Accident. 5 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1st 1971 to April 6th 1971 that (I) (we) last saw the deceased alive on April 6th 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Whelton MB. BCh MRCP DEGREE				23B. DATE SIGNED April 6th 71	
23C. PHYSICIAN'S NAME (Type) JOHN C. WHELTON MB. MRCP DEGREE				23D. ADDRESS Good Samaritan Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Arbutus, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Caroline			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Wright		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 5 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1205 Holbrook St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 5 71 12:10 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1001			
6. SEX male	7. RACE colored	C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday) 57	E. STREET AND NUMBER 1205 Holbrook St.	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218 36 6579		18. INFORMANT ADDRESS UNKNOWN	
19. CAUSE OF DEATH 4/12/71		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED 4/6/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried	24B. DATE 4-13-71	24C. NAME OF CEMETERY or CREMATORY MT. CALVARY CEM.	24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL CO. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971	25B. NAME OF REGISTRAR Robert E. Farley, M.D.	25C. FUNERAL DIRECTOR CALVIN B. SCRUBBS	ADDRESS 1412 E. Preston Street.

12 14 15

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3539

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN LOUIS WRIGHT

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home & Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

4

10

1971

5:30 a

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

501

6. SEX

male

7. RACE

negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

JUNE 6, 1924

10. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

130 N. Aisquith St.

11. BIRTHPLACE (State or foreign country)

BALTO., Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TECH.

14B. KIND OF BUSINESS OR INDUSTRY

HOSPITAL

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WORLD 7-7-43-9-24-45 215-16-06-50

17. SOCIAL
SECURITY NO.

18. INFORMANT

Mrs. Vera Wright

ADDRESS

130 Aisquith St.

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/10/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-15-71

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary CEM.

24D. LOCATION (City, town, or county) (State)

Cedar Hill

Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 12 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

CALVIN B. SCRUGGS

ADDRESS

1412 E. Preston St.

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3540	
<div style="font-size: 1.5em; font-weight: bold;">E-462</div> <div style="font-size: 1.5em; font-weight: bold;">71 3540</div>		CERTIFICATE OF DEATH			
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
JOHANNA B. EHLERS		APR. 5, 1971		1.06 A. M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN D. INSIDE CITY LIMITS?	
00 2032 N. Bentalou St.,		Md. Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		8. DATE OF BIRTH 7-15-1878	
11. BIRTHPLACE (State or foreign country) Germany		9. AGE (In years last birthday) 92		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Frank L. Hopkins	
ADDRESS 2032 N. Bentalou St.					
MEDICAL CERTIFICATION I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, or as a consequence of:			
		(B) Due to, or as a consequence of:			
		(C) Due to, or as a consequence of:			
		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1970 to Apr. 4, 1971, that (I) (we) last saw the deceased alive on Apr. 2, 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George E. Shannon M.D.		23B. DATE SIGNED April 5, 1971		23C. PHYSICIAN'S NAME (Type) George E. Shannon	
23D. ADDRESS Medical Arts Bldg.,					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-1971		24C. NAME OF CEMETERY or CREMATORY London Park	
24D. LOCATION Baltimore		(City, town, or county)		(State) Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR G. Howard Strong	
ADDRESS 3207 W. North Ave.,					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3541</u>	
71 3541				CERTIFICATE OF DEATH	
BIRTH NO. <u>G-453</u>		1. NAME OF DECEASED (Type or Print) <u>GILLAND, EDNA MAY</u>		2. DATE AND HOUR OF DEATH <u>APRIL 03, 1971</u> <u>5:05P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1902</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>112 SO STRICKER STREET 21223</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05-08-00</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MARTIN BRADY</u>		14. MOTHER'S MAIDEN NAME <u>CLARA ()</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>WILKENS AVE BALTO MD. 21229</u> <u>ST AGNES HOSPITAL RECORDS CATON &</u>	
18. <u>4/2/3</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal CHF.</u> <u>Pulm. edema.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary disease. Old MI.</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>APRIL 1</u> 19 <u>71</u> to <u>APRIL 3</u> 19 <u>71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>APRIL 3</u> 19 <u>71</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ching Hui Tsai</u>		23B. DATE SIGNED <u>4/3/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Ching-Hui Tsai, M.D.</u>	
23D. ADDRESS <u>Saint Agnes Hospital.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-7-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>		25B. NAME OF REGISTRAR <u>John E. Varley, R.N.</u>	
25C. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Rd.-21206</u>		25D. ADDRESS			

Page

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

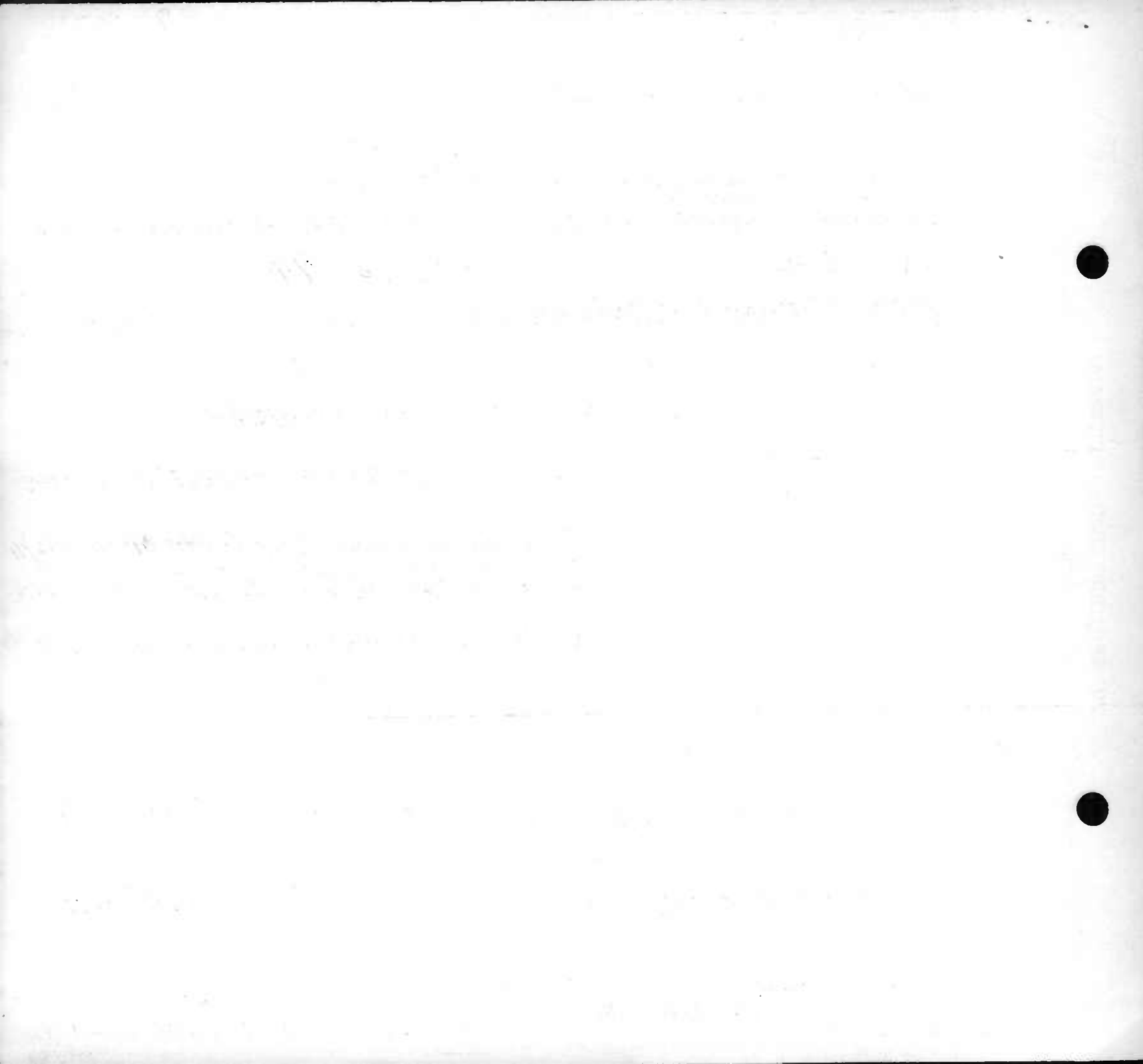
101

101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>71 3542</p>		<p>CERTIFICATE OF DEATH</p>		<p>71 3542</p>	
<p>BIRTH NO. 5-530</p>		<p>REG. NO. _____</p>			
<p>1. NAME OF DECEASED (Type or Print) HARRY B. SCHMIDT</p>		<p>2. DATE AND HOUR OF DEATH 4/2/71 at 1:00 P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE GORDON SAMARITAN HOSPITAL 5601 ROCK RAVEN BLVD BALTIMORE MARYLAND 21239</p>		<p>A. STATE MARYLAND</p>		<p>B. COUNTY 2745</p>	
		<p>C. CITY OR TOWN BALTIMORE</p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
		<p>E. STREET AND NUMBER 3914 PINewood AVENUE 21206</p>			
<p>5. SEX M</p>	<p>6. RACE CAU</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11/03/96</p>	<p>9. AGE (In years lost birthday) 74</p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WARD FOREMAN PEN. RAILROAD CO.</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A</p>	
<p>13. FATHER'S NAME HARRY BERNARD SR.</p>		<p>14. MOTHER'S MAIDEN NAME McCLAINIE, Margaret ELLIEN</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 417-07740</p>		<p>17. INFORMANT HOSPITAL RECORDS</p>	
<p>18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH BRONCHOPULMONARY RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL EMBOLUS (MULTIPLE EPISODES - EMBOLIC) - APHASIA GENERALIZED ARTERIOSCLEROSIS</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES 3/1/71 - 4/2/71 LONG STANDING</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD - RECENT MYOCARDIAL INFARCT</p>		<p>2/10/1971</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from March 19 1971 to April 2nd 1971 that (I) (we) last saw the deceased alive on April 2nd 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Caridad E. Gonzalez M.D.</p>		<p>23B. DATE SIGNED 4/2/1971</p>		<p>23C. PHYSICIAN'S NAME (Type) Caridad E. Gonzalez M.D.</p>	
<p>23D. ADDRESS</p>		<p>23E. ADDRESS</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) burial</p>		<p>24B. DATE 4-6-71</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Pinewood Cemetery</p>	
<p>24D. LOCATION (City, town, or county) Baltimore, Maryland</p>		<p>24E. LOCATION (State) _____</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. APR 12 1971</p>		<p>25B. NAME OF FUNERAL HOME John C. Miller Inc</p>		<p>25C. FUNERAL DIRECTOR John C. Miller</p>	
<p>25D. ADDRESS 4615 Belair Road-21206</p>		<p>25E. ADDRESS</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3543	
1. NAME OF DECEASED (Type or Print) George A. Kirchner		2. DATE AND HOUR OF DEATH 4/6/71 4 10 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 603 C. CITY OR TOWN Baltimore 2131 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 18 N. MADRIRA ST. 2131			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-30-94	9. AGE (in years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Transt Co.		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Richard G. Kirchner		14. MOTHER'S MAIDEN NAME unknown.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT H. Thumeyer ADDRESS 1202 Jones St - 21223	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/12/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED I		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/12 1971 to 3/31 1971 and that (I) (we) last saw the deceased alive on 3/31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 4/6/71		23C. PHYSICIAN'S NAME (Type) Robert Levy, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/71		24C. NAME OF CEMETERY OR CREMATORY Crest Lawn Cem.	
24D. LOCATION (City, town, or county) (State) Howard Co. Md.		25A. FUNERAL DIRECTOR John J. Gannon ADDRESS [Address]			

1941

12-12-41

11-12-41

12-12-41

X

12-12-41

12-12-41

12-12-41

12-12-41

12-12-41

12-12-41

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3544	
B-653 71 3544		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ADA BARNETT		April 10, 1971 12:50 P. M.			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. FULL NAME OF HOSPITAL OR INSTITUTION		8. STREET AND NUMBER		9. DATE OF BIRTH	
Melchor Nursing Home 2327 North Charles Street		408 Ilchester Avenue		June 6, 1882	
10. SEX	11. RACE	12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	13. AGE (In years last birthday)	14. If Under 1 Yr. Months	15. If Under 24 Hrs. Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	88		
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		17. KIND OF BUSINESS OR INDUSTRY		18. BIRTHPLACE (State or foreign country)	
Housewife		Retired		Baltimore, Maryland	
19. FATHER'S NAME		20. MOTHER'S MAIDEN NAME		21. CITIZEN OF WHAT COUNTRY?	
Christopher Fryer		Eve ?		U.S.A.	
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		23. SOCIAL SECURITY NO.		24. INFORMANT ADDRESS	
NO		214 22 8 4565		Mrs Ruth C. Funk 404 Ilchester Ave.	
25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		26. CAUSE OF DEATH		27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebral Vascular Accident		few minutes	
28. ANTECEDENT CAUSES		29. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Generalized Arteriosclerosis		Several years	
30. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		31. (B) DUE TO, OR AS A CONSEQUENCE OF:			
		32. (C) DUE TO, OR AS A CONSEQUENCE OF:			
33. MEDICAL CERTIFICATION		34. DATE OF OPERATION		35. CONDITION FOR WHICH OPERATION WAS PERFORMED	
36. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		37. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		38. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
39. 21D. TIME OF INJURY (APPROX.)		40. 21E. INJURY OCCURRED		41. 21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
42. I certify that (I) (this hospital) attended the deceased from <u>Man.</u> 19 <u>69</u> to <u>Apr. 1</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>Apr. 1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
43. 23A. SIGNATURE		44. 23B. DATE SIGNED		45. 23C. PHYSICIAN'S NAME (Type)	
<i>Loy Zimmerman</i>		4/12/71		Loy Zimmerman M.D.	
46. 24A. BURIAL CREMATION, REMOVAL (Specify)		47. 24B. DATE		48. 24C. NAME OF CEMETERY or CREMATORY	
Burial		4/13/71		Loudon Park	
49. 25A. DATE REC'D BY HEALTH DEPT.		50. 25B. NAME OF REGISTRAR		51. 25C. FUNERAL DIRECTOR ADDRESS	
APR 12 1971		Robert E. Taylor, M.D.		Henry Sander & Sons Inc. Baltimore Maryland 21213	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3545	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) HOOPER, CALVIN		2. DATE AND HOUR OF DEATH APRIL 8, 1971 - 12:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Anderson Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5502 Fernpark Avenue 21207			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-6-1888	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hoopersville, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benjamin Hooper		14. MOTHER'S MAIDEN NAME Booze			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-0788		17. INFORMANT Gertrude B. Hooper ADDRESS 5502 Fernpark Avenue	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBRO-VASCULAR THROMBOSIS <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL ARTERIOSCLEROSIS </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS 10 YRS. </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION OCT 1, 1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 1, 1969 to APRIL 8, 1971 that (I) (we) last saw the deceased alive on APRIL 6, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein, M.D.				23B. DATE SIGNED APRIL 8, 1971	
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN, M.D.				23D. ADDRESS 6001 PARK HEIGHTS AVE BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971 25B. NAME OF REGISTRAR J. E. [Signature] 25C. FUNERAL DIRECTOR Armacost Funeral Chapel ADDRESS -4600 Liberty Hts			

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3546</u>	
1. NAME OF DECEASED (Type or Print) <u>Dutton RICHARD</u>		2. DATE AND HOUR OF DEATH <u>9-5-71 9:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		A. STATE <u>M.D.</u>		B. COUNTY <u>Harford</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Hagerstown</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>38</u>		E. STREET AND NUMBER <u>3312 Emmorton Rd</u>			
5. SEX <u>M</u>	6. RACE <u>cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-71</u>	9. AGE (In years last birthday) <u>9</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>RICHARD DUTTON</u>		14. MOTHER'S MAIDEN NAME <u>BAUGUESS, Yella Joyce</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father - 3312 Emmorton Rd. Hagerstown Md. 20609</u>	
18. <u>226.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cranio-pharyngoma</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>13-30-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from <u>3-23</u> 19 <u>71</u> to <u>4-5</u> 19 <u>71</u> that (i) (we) last saw the deceased alive on <u>4-5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel H. Herbert</u>		23B. DATE SIGNED <u>4-5-71</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>	
23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Grove Baptist Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Tarrington Funeral Home - Hagerstown Md.</u>			

S-652

71 3547

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3547

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SHERRY LYNN SWEARINGEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 4, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 4, 1971 3:25 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Belair	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 18		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 141 Mc Cormick Street	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wayne W. Swearingen	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator M & S.		15. MOTHER'S MAIDEN NAME Margie Louise White	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 217-60-2224	
18. INFORMANT * J H B @ E.		ADDRESS	
19. E 816.0 I CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. #22 3 ml. W. Aberdeen, Md.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-4-71 2:25 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver of auto - ran off road and subject thrown out	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/2/1971	
24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR John E. Taylor R.D.	
25C. FUNERAL DIRECTOR Walter A. ...		ADDRESS Walter A. ...	

THE UNIVERSITY OF CHICAGO
LIBRARY

1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

W-324

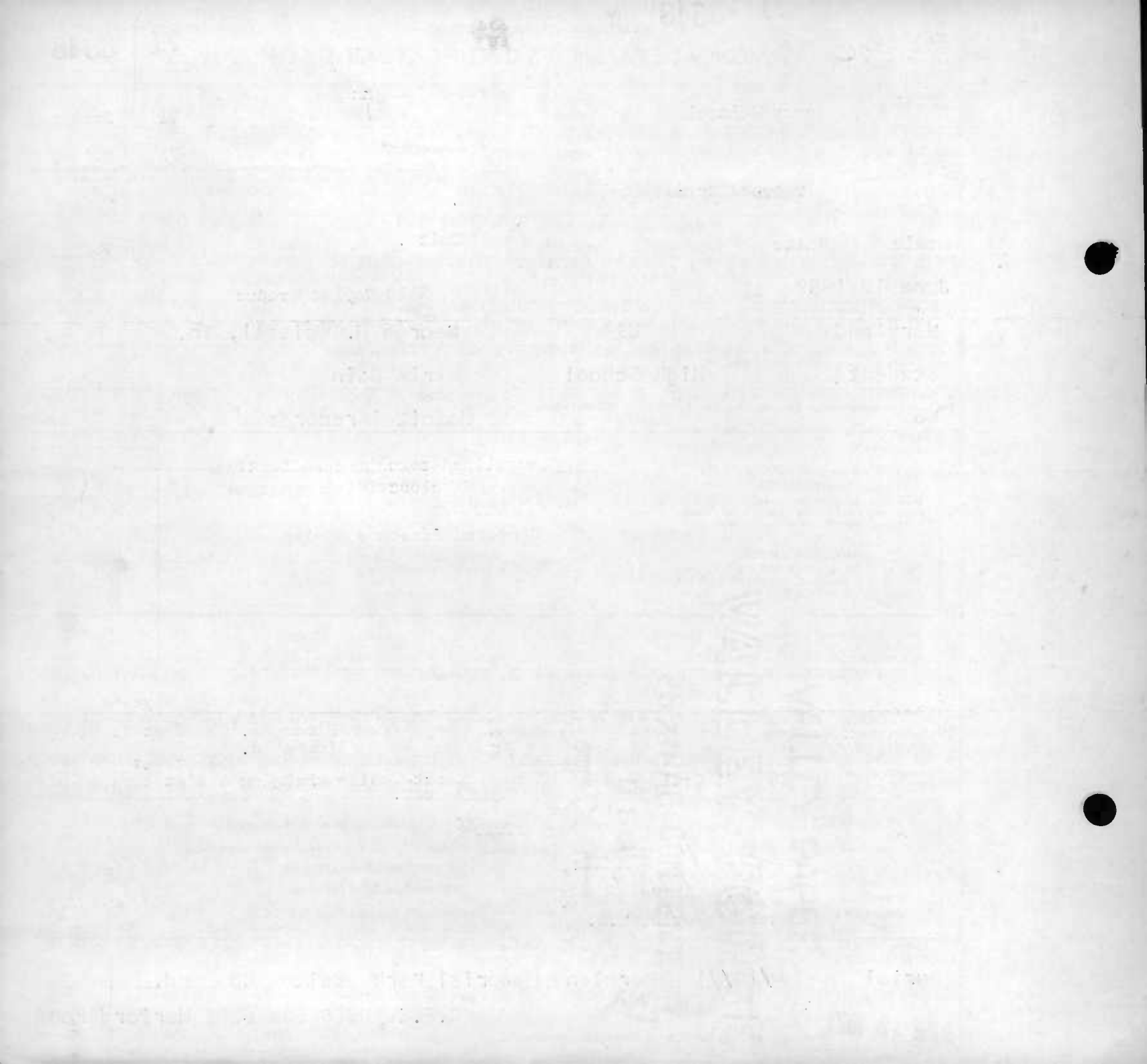
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3548

BIRTH NO.

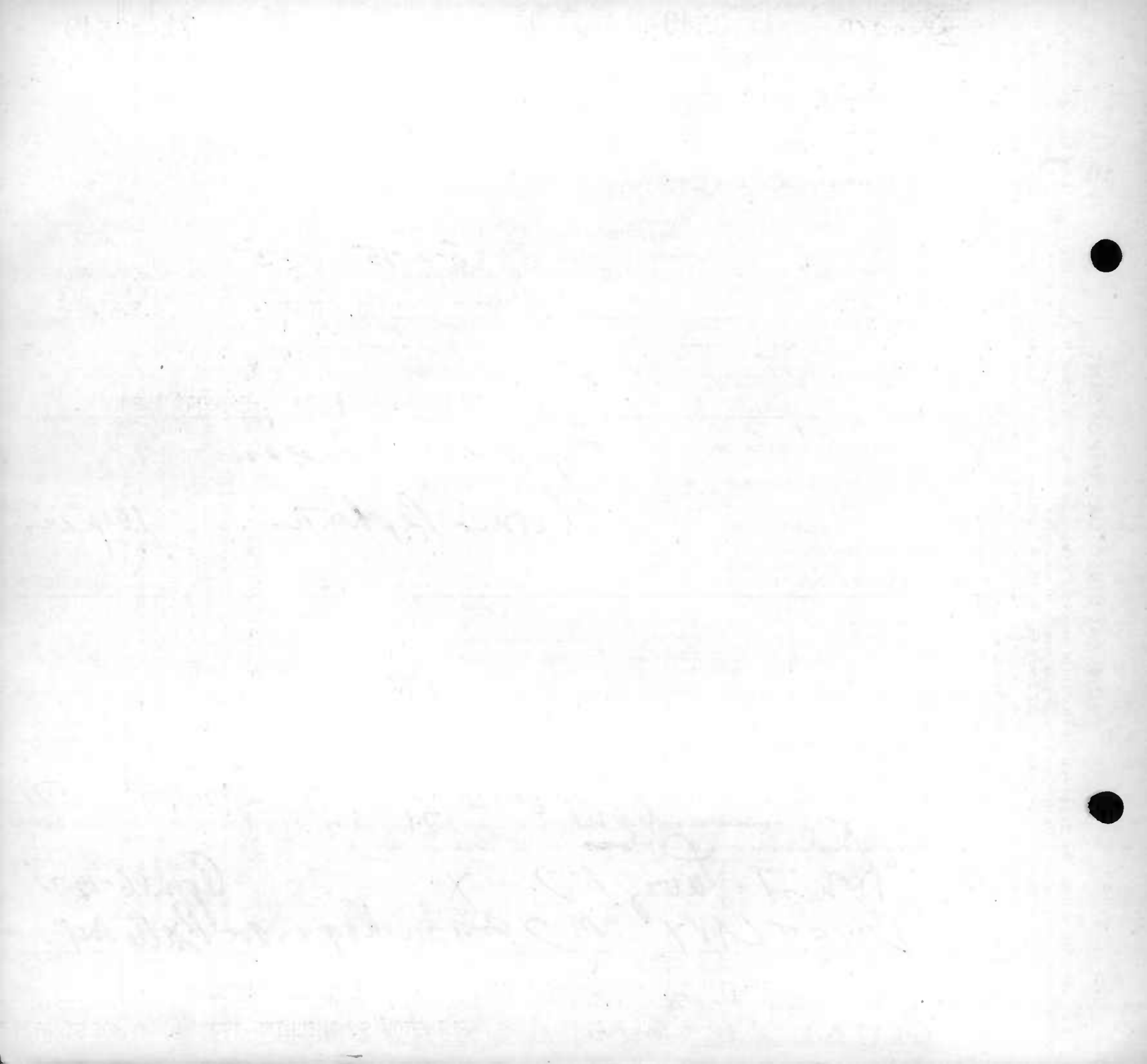
1. NAME OF DECEASED (Type or Print) Jerry Weitzel		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 7 71 5:13 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 7 71 5:13 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH June 10 1952		10. AGE (In years lost birthday) 18	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY High School	
15. MOTHER'S MAIDEN NAME Marie Cain		E. STREET AND NUMBER 2110 Taylor Avenue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Hospital records		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized toxemia complicating clostridial gangrene		CAUSE OF DEATH Generalized toxemia complicating clostridial gangrene	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Compound fracture of leg		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ROAD	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hines Rd. 610 feet S. of 5300 Simmon Rd.		22D. TIME OF INJURY (APPROX.) 3 28 71 7:21 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was hit by auto while changing a flat tire on his car.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		DATE SIGNED 4/8/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/71	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Balto Co Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Harford	
25C. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3549	
<div style="display: flex; justify-content: space-between;"> D-000 71 3549 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Catherine DAY		2. DATE AND HOUR OF DEATH 4-5-71 7:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2712			
FULL NAME OF HOSPITAL OR INSTITUTION 90 MT. Sinai Nursing Home 4613 Park Heights Ave		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 426 Hutchens Ave					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-15	9. AGE (In years last birthday) 55	If Under 1 Yr. Months; Days If Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST MORELAND, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME PALMER TATE		14. MOTHER'S MAIDEN NAME JOSEPHINE SNOW			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM L. DAY ADDRESS -839 N. FREMONT AVENUE	
18. 712, 21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive C-V Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Nephritis.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Nephritis. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 4 19 71 to April 5 19 71 , that (I) (we) last saw the deceased alive on April 4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Louis T. Lavy M.D.		23B. DATE SIGNED April 6-1971			
23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY		23D. ADDRESS M.D. 3502 W. Rogers Ave Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-10-71		24C. NAME OF CEMETERY or CREMATORY CARVER MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) LAUREL, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR ARLINGTON S. PHILLIPS ADDRESS -1727 N. MONROE ST 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

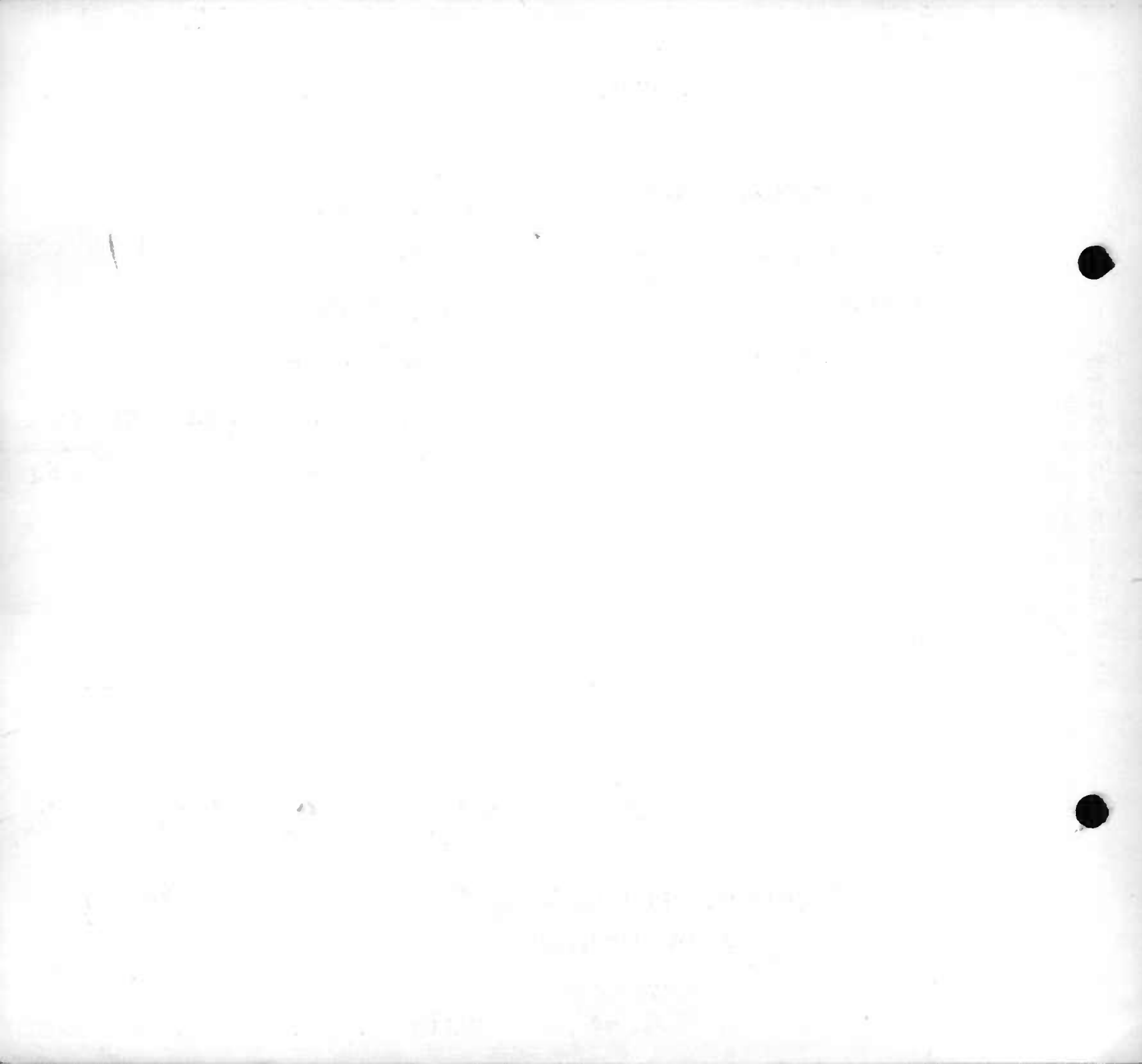
BIRTH NO. K-200		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3550	
1. NAME OF DECEASED (Type or Print) Connie Rice			2. DATE AND HOUR OF DEATH April 7, 1971 12²⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1513		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Pleasant Manner Nursing Home 904 300 Park Hgts. Ave. Baltimore Md.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Calais 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7-4-1913		9. AGE (In years lost birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator op.			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Alexander Rice			14. MOTHER'S MAIDEN NAME Anna Laura Henes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 224-16-7253		17. INFORMANT Mollie Clary Lawrenceville, VA.
18. 4/12/71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Heart Failure			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart + C.V.D.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Left Hemiparesis due to CVA			(B) DUE TO, OR AS A CONSEQUENCE OF: Right Hemiparesis due to CVA		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1970 to April 1971 , that (I) (we) last saw the deceased alive on Mar 31, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank J. Kuhn				23B. DATE SIGNED 4-7-71	
23C. PHYSICIAN'S NAME (Type) Robert E. Taylor M.D.				23D. ADDRESS 1727 M. Mount St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/12/71		24C. NAME OF CEMETERY or CREMATORY Family	
24D. LOCATION (City, town, or county) (State) Marydithville V.A.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR William S. Phillips			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

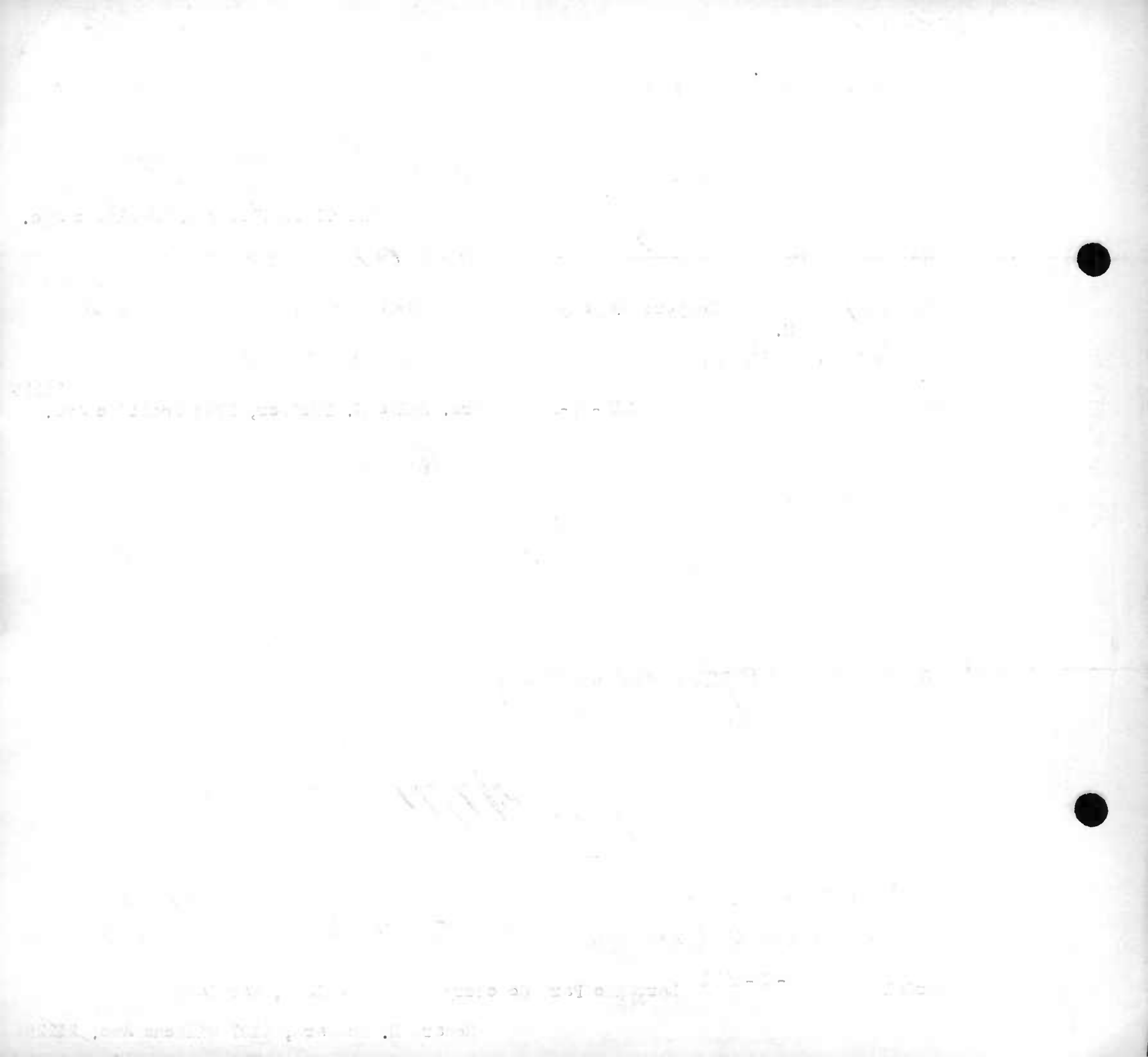
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3551	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">APRIL 6, 1971 12:50 p.m.</div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1512 C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 2814 HILDALE AVENUE			
5. SEX FEMALE		6. RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH SEPT-5-1926	
13. FATHER'S NAME WALTER MOORE		14. MOTHER'S MAIDEN NAME MARTHA ROUNDTREE		9. AGE (In years last birthday) 44	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 238-58-5017		17. INFORMANT VERNIE B. CALDWELL ADDRESS 1118-J CHERRY HILL ROAD	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 wks </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 No		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/16 19 70 to 6 Apr 19 71 that (I) (we) last saw the deceased alive on 3/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Beymour Weiner M.D.				23B. DATE SIGNED 8 Apr 71	
23C. PHYSICIAN'S NAME (Type) BEYMOUR WEINER		23D. ADDRESS ARLINGTON S. PHILLIPS-1721 N. MONROE ST-21217			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-9-71		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 12 1971			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS ARLINGTON S. PHILLIPS-1721 N. MONROE ST-21217			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

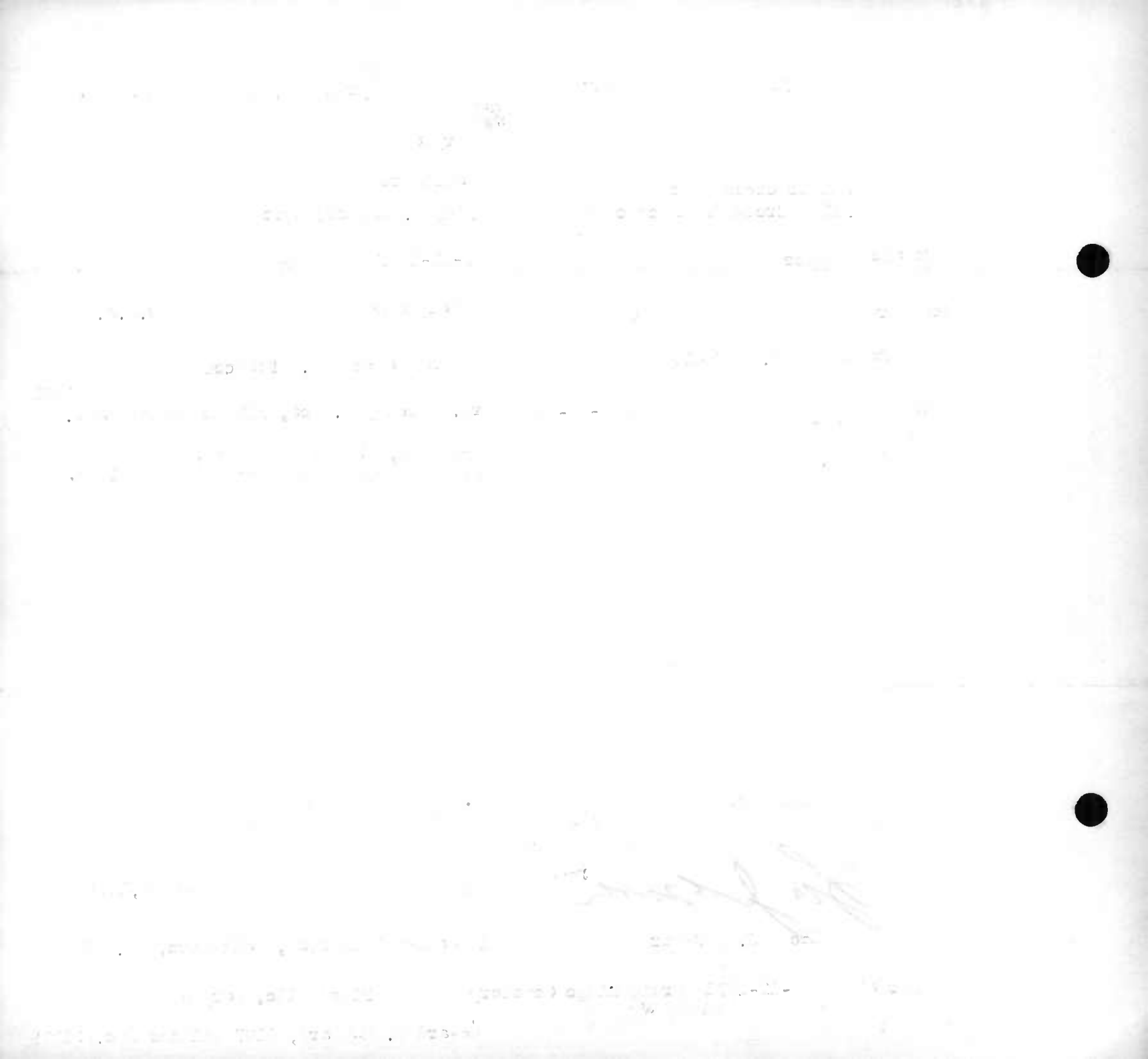
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3552	
BIRTH NO. P-160		71 3552			
1. NAME OF DECEASED (Type or Print) GEORGE W. PFEIFER			2. DATE AND HOUR OF DEATH April 8, 1971 12:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43			A. STATE MARYLAND		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			C. CITY OR TOWN BALTIMORE		
			E. STREET AND NUMBER 3708 Coolidge Ave.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-07	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINEST		10B. KIND OF BUSINESS OR INDUSTRY Koppers Company		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME GEORGE PFEIFER			14. MOTHER'S MAIDEN NAME LILLIAN FLOYD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-5366		17. INFORMANT Mrs. Julia E. Pfeifer, 3708 Coolidge Ave.	
18. 441.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Ruptured abdominal aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4-7-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aneurysm		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/7/71 19 to 4-8-71 19 that (I) (we) last saw the deceased alive on 4/8/71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Canizares M.D.				23B. DATE SIGNED 4/8/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROBERTO R. CANIZARES		South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-1971		24C. NAME of CEMETERY or CREMATORY Corson Park Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1971			
25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

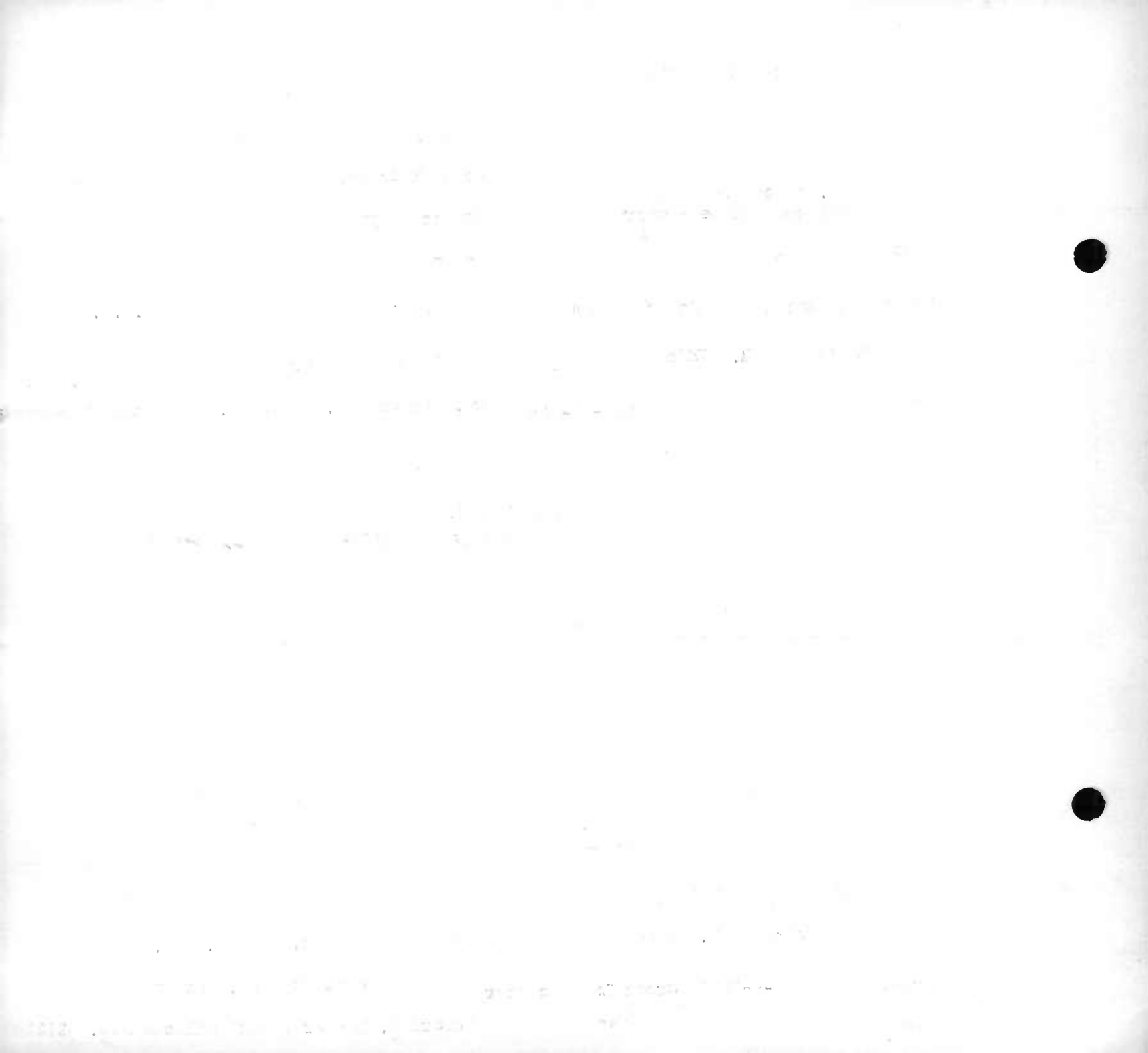
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3553</u>	
BIRTH NO. <u>U-400</u>		71 3553			
1. NAME OF DECEASED (Type or Print) <u>IDA A WHOLEY</u>			2. DATE AND HOUR OF DEATH <u>April 8, 1971</u> <u>3:45 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Silver Cross Home</u> <u>5124 Greenwich Avenue 21229</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1202</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input type="checkbox"/>
			E. STREET AND NUMBER <u>3043 N. Calvert Street</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-1883</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James R. Wholey</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth W. Peaster</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-44-0180</u>		17. INFORMANT ADDRESS <u>Mrs. Dorothy M. Rea, 5721 Edmondson Ave. 21228</u>
18. I <u>1980</u> I <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Carcinoma, Abdominal Cavity,</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE site of origin undetermined</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>1 Yr.</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the doctor) attended the deceased from <u>Feb.</u> 19 <u>68</u> to <u>April</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Leo J. Gaver</u> DEGREE				23B. DATE SIGNED <u>April 9, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver</u> DEGREE				23D. ADDRESS <u>1 Mallow Hill Road, Baltimore, Md. 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-12-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>			
25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>4107 Wilkens Ave. 21229</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

10-300 71 3554		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3554	
1. NAME OF DECEASED (Type or Print)		CHARLES WILLIAM WADE		2. DATE AND HOUR OF DEATH April 6, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkens Avenue & Caton		A. STATE Maryland B. COUNTY Howard			
		C. CITY OR TOWN West Friendship		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER Route # 32			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-1910	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing & Heating		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Louis R. Wade		14. MOTHER'S MAIDEN NAME Anne Gary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-32-7947		17. INFORMANT Mrs. Margaret M. Wade, Rt. # 32 West Friendship	
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION (B) A CVD - PROLONGED SPASMS DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/1/1957 to 4/6/1971 that (I) (we) last saw the deceased alive on 4/5/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John H. Shaw		23B. DATE SIGNED 4/7/71		23C. PHYSICIAN'S NAME (Type) John H. Shaw	
23D. ADDRESS 5800 Edmondson Ave., Balto., Md.		23E. ATTENDING PHYSICIAN Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-9-1971		24C. NAME OF CEMETERY OR CREMATORY Crest Lawn Cemetery	
24D. LOCATION Howard County, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 13 1971			
24F. NAME OF REGISTRAR Howard H. Hubbard		24G. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3555	
BIRTH NO. 4-532		71 3555		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HANDS, IVAN			2. DATE AND HOUR OF DEATH 4/6/71 10:37A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			A. STATE MARYLAND BALTIMORE 5300		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 607 COLERAINE RD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 6 05	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LINESMAN			10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC CO.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Adam Hands		
14. MOTHER'S MAIDEN NAME Iva Goodwin			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212055794			17. INFORMANT ST AGNES HOSPITAL WILKENS & CATON BALTO MD 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia</i> (B) <i>uremia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Congestive Heart failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from 3/25 1971 to 4/6/ 1971 that (I) (we) last saw the deceased alive on 4/6/ 1971 and that in my ^{XX} (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) not view the body after death.					
23A. SIGNATURE <i>A. Shams, M.D.</i>			23B. DATE SIGNED 4-6-71		
23C. PHYSICIAN'S NAME (Type) A SHAMS, M.D.			23D. ADDRESS BALTO MD 21229 ST. AGNES HOSPITAL CATON & WILKENS AVES		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-9-1971		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1971			
25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave, 21229			

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

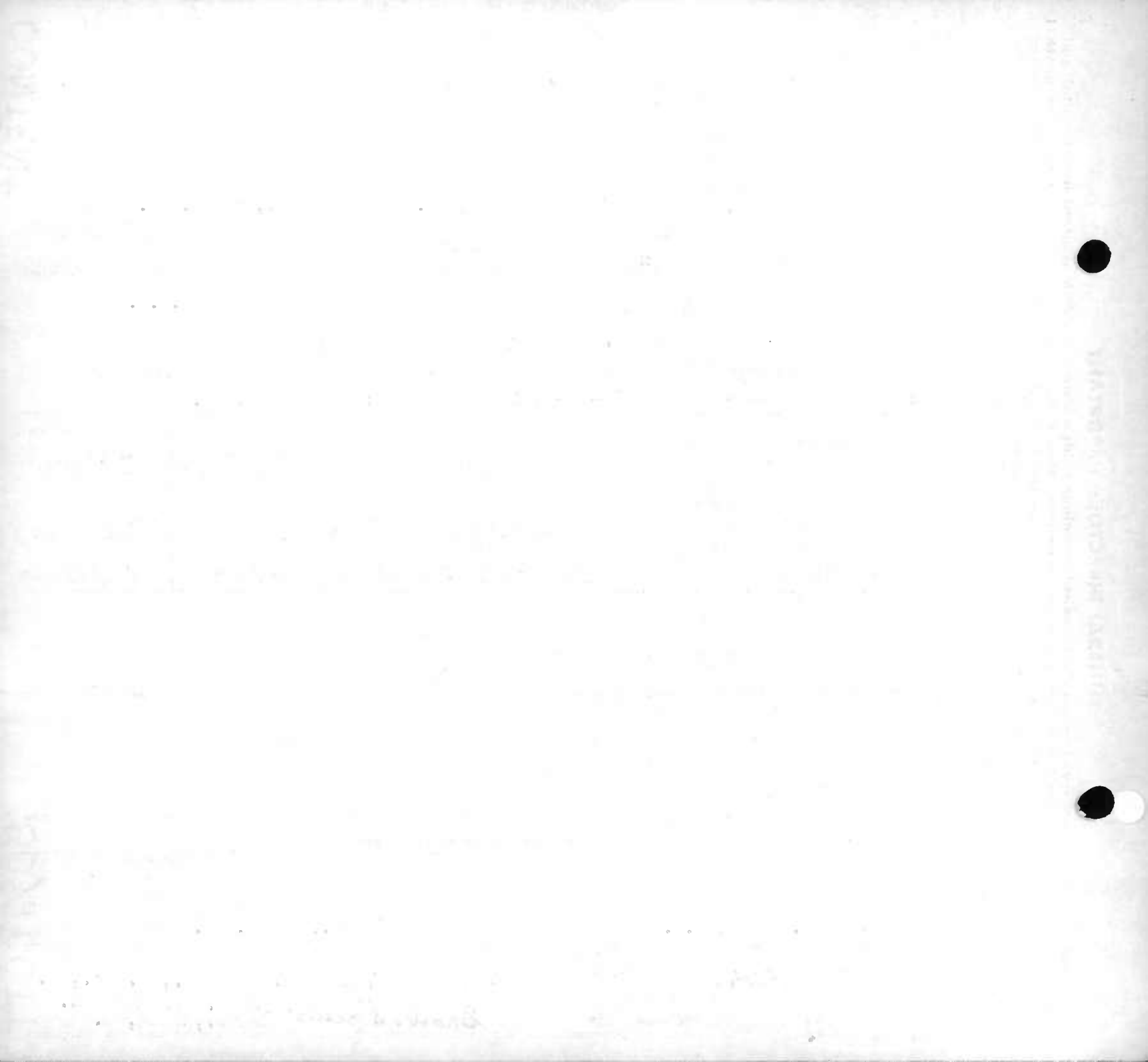
RGB

BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO.	71 3556
G-152 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Betty Joyce Gubbins		2. DATE AND HOUR OF DEATH April 7, 1971 12: 15 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2X 3100 Wyman Parkway		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE: Va. B. COUNTY: Fairfax V-43 C. CITY OR TOWN : Lorton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER : 8710 La Grange Street				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/17/58	9. AGE (In years last birthday) 12	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME E. Richard Gubbins				14. MOTHER'S MAIDEN NAME Joyce Mc Laurin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pyelonephritis Recto-vaginal fistula				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks. 6 wks. 5 mos.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute lymphocytic leukemia				4 yrs.		
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Feb. 18 19 71 to Apr. 7 19 71 that (I) (we) last saw the deceased alive on Apr. 7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Samuel P. Ward, M.D.				23B. DATE SIGNED 4/7/71		
23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/71		24C. NAME OF CEMETERY OR CREMATORY Culpeper Nat Cemetery		24D. LOCATION (City, town, or county) (State) Culpeper Va.
25A. DATE REC'D BY HEALTH DEPT. APR 12 1971		25B. NAME OF REGISTRAR 26. 21. 26. 21. 26. 21.		25C. FUNERAL DIRECTOR ADDRESS Demaine Funeral Home Alexandria, Va.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

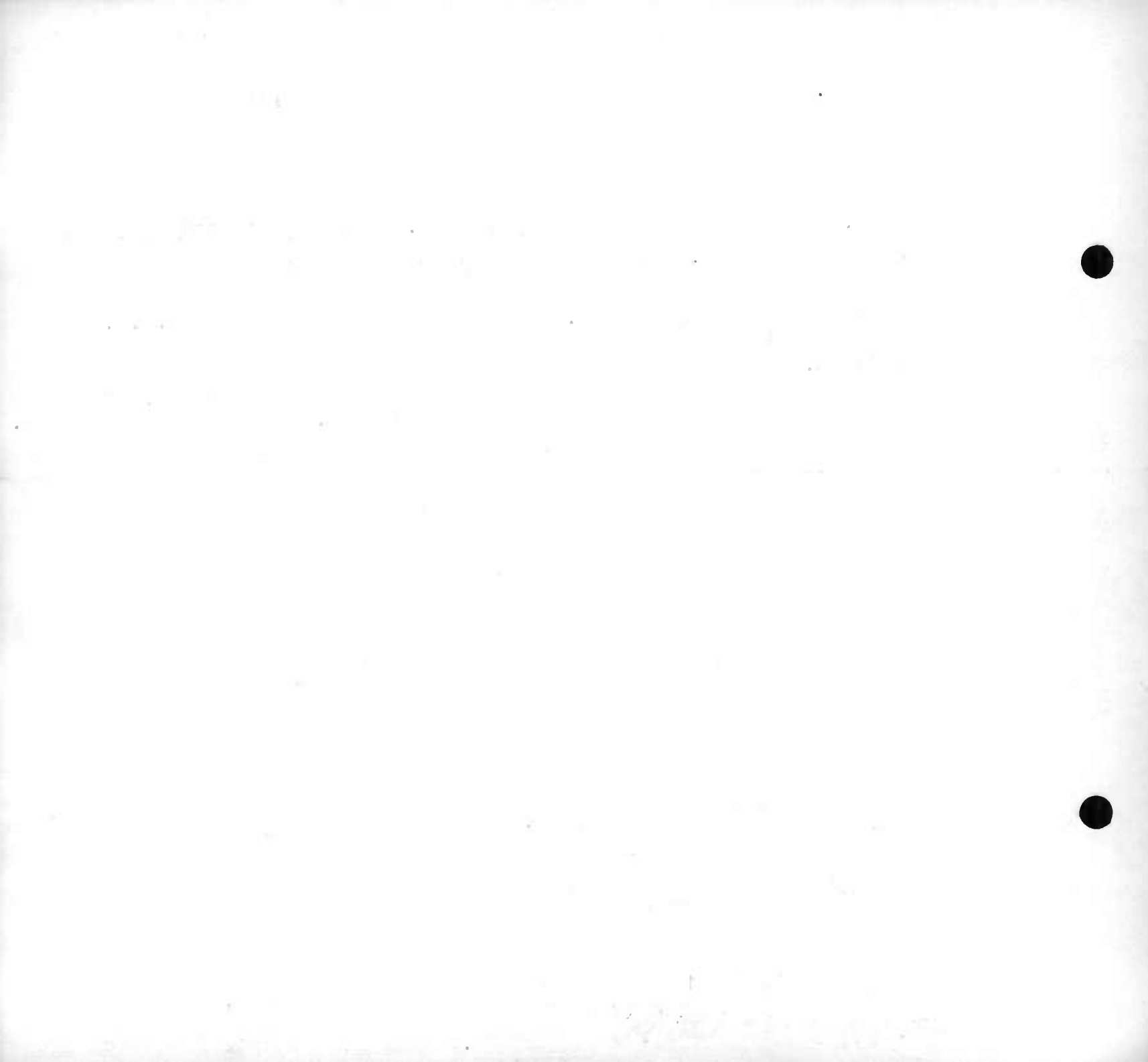
BIRTH NO. B-200				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3557	
1. NAME OF DECEASED (Type or Print) Maizie Boyce (MAZIE E. BOYCE)				2. DATE AND HOUR OF DEATH 1:45 AM. 4/8/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland		B. COUNTY 2610	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-18	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 52		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME David Trimmer (David W. Trimmer)				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME Bertha Warfield		16. SOCIAL SECURITY NO. 214-14-9141	
17. INFORMANT BCH Records: Baltimore, Md. 21224				18. CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 430.91				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA & SEPSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) BLEEDING ANEURYSM DUE TO, OR AS A CONSEQUENCE OF:		72 hrs.	
				(C) DOUBLE BERRY ANEURYSM		3 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5/8/71 19 71 to 4/8 19 71 that (1) (we) last saw the deceased alive on 4/8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John J. Duwel				23B. DATE SIGNED 4/8/71		23C. PHYSICIAN'S NAME (Type) John J. Duwel, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-12-71		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles S. Seiler	
26A. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Balto. Md. 21224				26B. ADDRESS 901 S. Conkling St. Balto., 21224, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

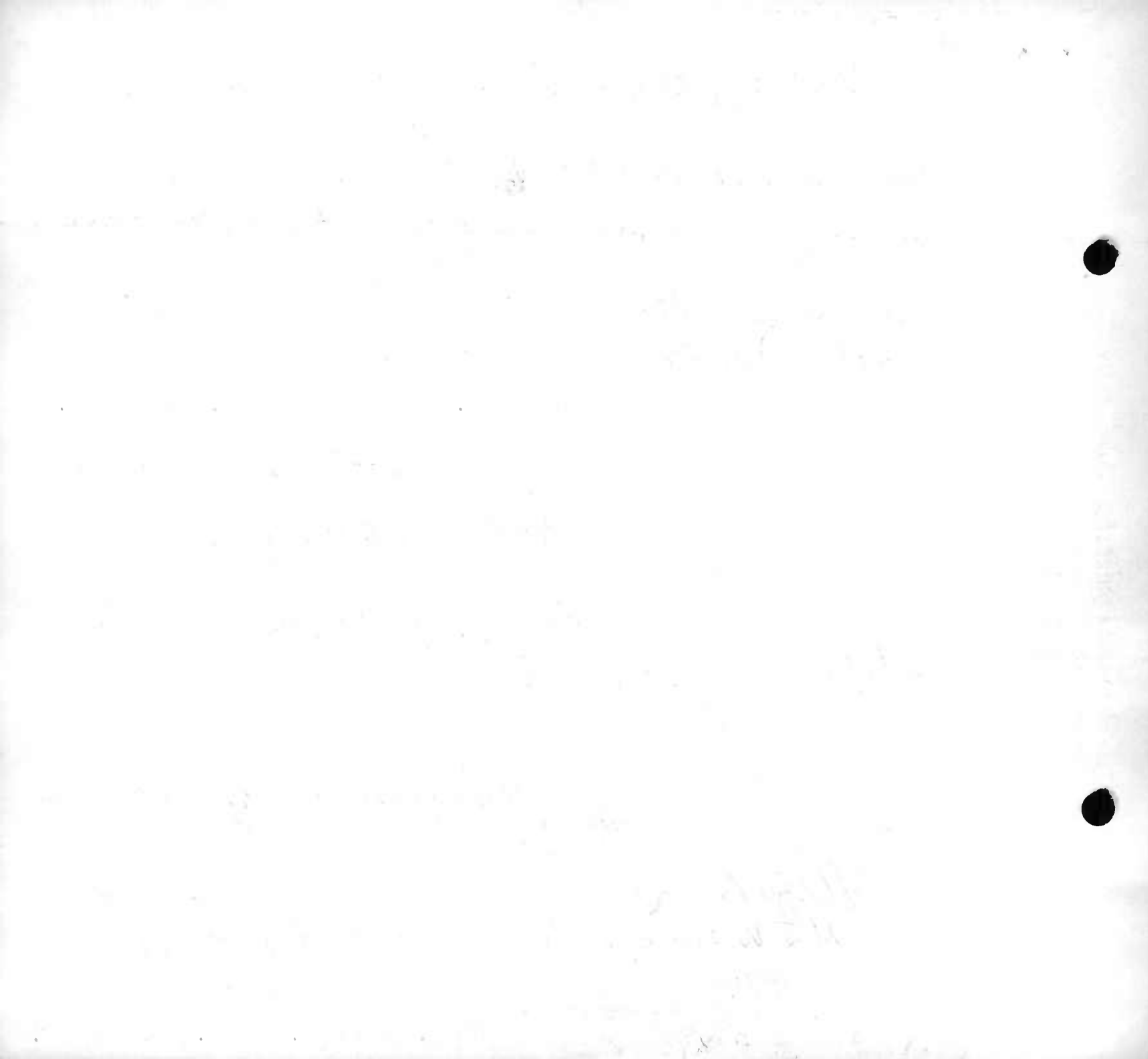
L-200 71 3558				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3558	
1. NAME OF DECEASED (Type or Print) <u>R. Emory Lewis</u>				2. DATE AND HOUR OF DEATH <u>April 9, 1971</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>206 S. Payson Street</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2002</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>323 S. Franklinton Road</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/1884</u>		9. AGE (In years last birthday) <u>86</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pattern Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Koppers Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alfred E. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ware</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Richard I. McCardy 1001 Wayne St.</u>	
				ADDRESS <u>Sandusky, Ohio</u>			
18. <u>2509</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CORONARY HEART DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC BRAIN DISEASE</u> <u>ARTERIOSCLEROSIS</u> <u>DIABETES MELLITUS</u>				CAUSE OF DEATH <u>CORONARY ATHEROSCLEROSIS</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC BRAIN DISEASE</u> <u>ARTERIOSCLEROSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 YRS</u> <u>? YRS</u> <u>? YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8-19-1955</u> to <u>4-9-1971</u> that (I) (was) last saw the deceased alive on <u>4-8-1971</u> and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.							
23A. SIGNATURE <u>Ray Oslman</u> M.D.				23B. DATE SIGNED <u>4-9-71</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4/12/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Huber</u>		25C. FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
71 3558				71 3558	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) DOWNEY, ELMER WARREN			2. DATE AND HOUR OF DEATH 4/8/71 10:40 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY -		
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38			E. STREET AND NUMBER 703 S. LINWOOD AVE 21224		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-04 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Food Getz co.		9. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME RICHARD Downey			14. MOTHER'S MAIDEN NAME Clara Carr		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 215-05-8128		17. INFORMANT Mrs. Mollie Downey 703 S. Linwood Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 395.9143.9			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cong. H. Failure DUE TO, OR AS A CONSEQUENCE OF Ischemic Transference (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Carcinoma of alveolus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 ms		
19A. DATE OF OPERATION 4/7/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA of alveolus		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 10 1971 to April 8th 1971 that (I) was last saw the deceased alive on April 8 1971 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Wizenberg			23B. DATE SIGNED 4/8/71		
23C. PHYSICIAN'S NAME (Type) M. J. Wizenberg, MD			23D. ADDRESS UNIV. OF MD Hospital, Baltimore, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1971			
25B. NAME OF REGISTRAR John A. Moran, Inc.		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-562 71 3560		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3560	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SOMERS, ELIZABETH E.		2. DATE AND HOUR OF DEATH 8 APRIL 1971 5A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX F	
FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW NURSING HOME		A. STATE MD.		6. RACE CAU	
ADDRESS OR LOCATION 101213 LIGHT STREET		B. COUNTY 701		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		C. CITY OR TOWN BALTIMORE		8. DATE OF BIRTH 5-12-01	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		9. AGE (In years last birthday) 69	
		E. STREET AND NUMBER 3113 E. MONUMENT STREET		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN BXXXXXX Bock	
14. MOTHER'S MAIDEN NAME MARGARET Seaman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-3094	
17. INFORMANT Dunwoody, Jr.		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
ADDRESS 4946 Mill Stream Ct.		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A.S.C.V. Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: myocardial failure			
		(B) DUE TO, OR AS A CONSEQUENCE OF: 4. u. infection			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II		19A. DATE OF OPERATION 4/12/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1 19 71 to April 8 19 71 that (I) (we) last saw the deceased alive on April 1 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum				23B. DATE SIGNED 4/8/71	
23C. PHYSICIAN'S NAME (Type) DR. JOSEPH S. BLUM				23D. ADDRESS 11154 CALVERT ST.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR John A. Moran, Inc.	
25C. FUNERAL DIRECTOR John A. Moran, Inc.		25D. ADDRESS 3000 E. Baltimore St.			

100



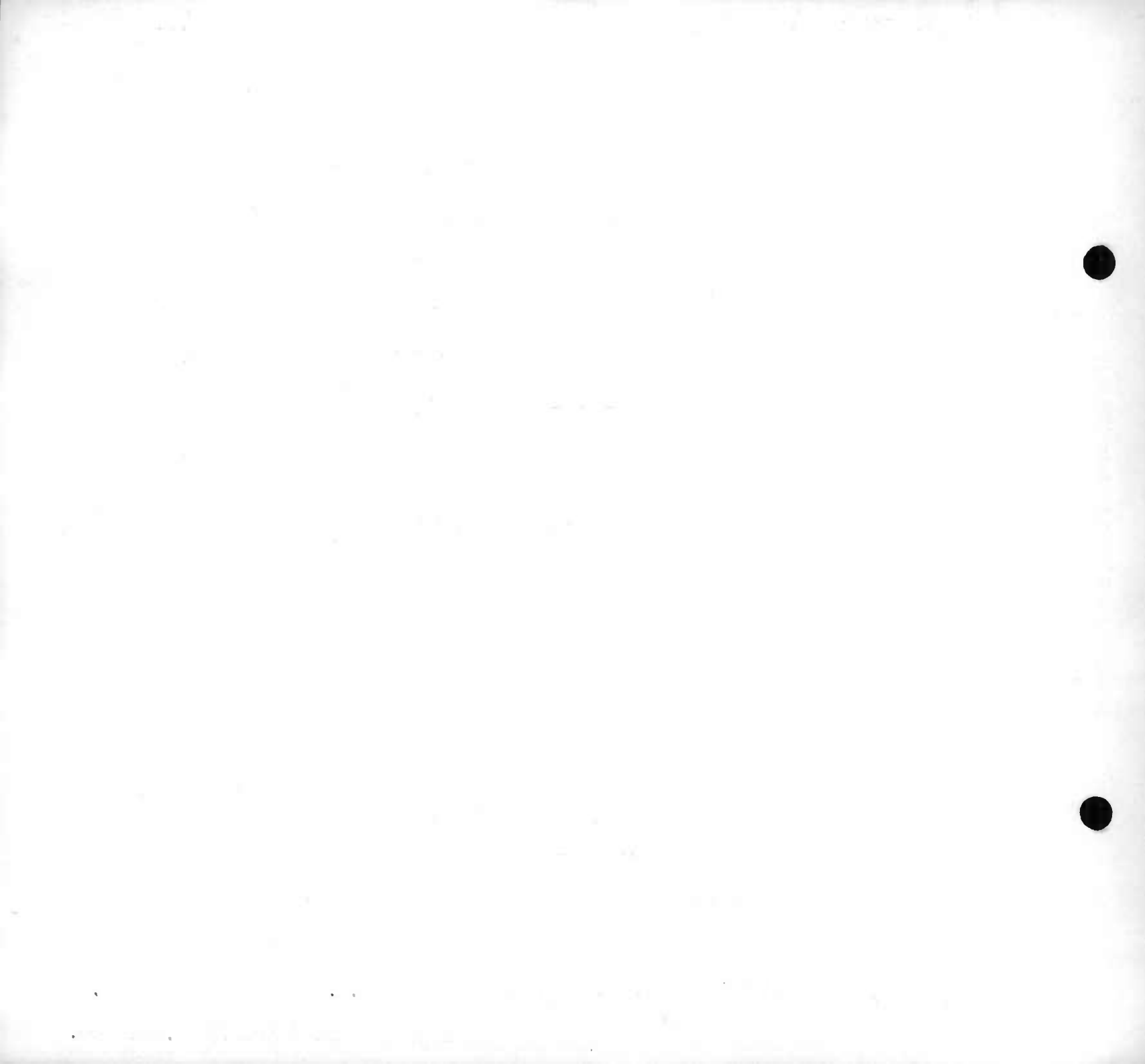
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
C-514		71 3561		71 3561	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		TACY NORBURY CAMPBELL		2. DATE AND HOUR OF DEATH 4-7-71 Approx 1 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3313 St. Paul Street		A. STATE Md.	
				B. COUNTY	
				C. CITY OR TOWN Baltimore City	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3313 St. Paul Street	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/6/1905	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Baltimore City	
13. FATHER'S NAME George S. Campbell		14. MOTHER'S MAIDEN NAME Grace Appold		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-44-0409		17. INFORMANT: Son Charles S. Dell, Jr. - Helena, Montana	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 43391		CAUSE OF DEATH Coronary thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: probable		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 50 to April 19 71, that (I) (we) lost saw the deceased alive on 8-25 19 58 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W P Benson, Jr.				23B. DATE SIGNED 4-8-71	
23C. PHYSICIAN'S NAME (Type) WILLIAM P. BENSON, JR. M.D.				23D. ADDRESS 3506 N. Calvert Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/9/71		24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO.	
				ADDRESS 108 W. North Av. Cit	



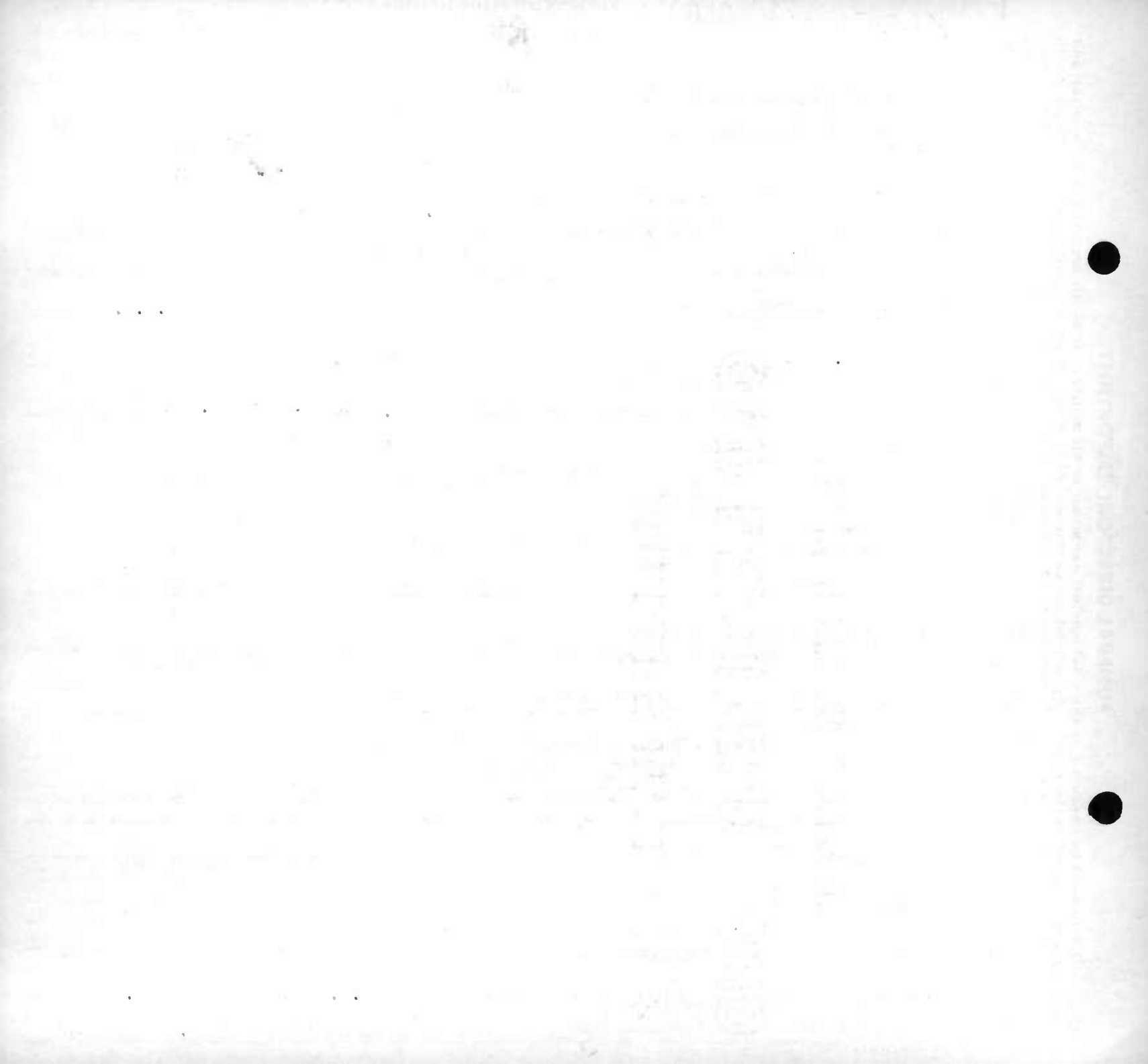
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				71 3562	
CERTIFICATE OF DEATH				REG. NO. 71 3562	
BIRTH NO. 7-520		1. NAME OF DECEASED (Type or Print) DORIS THOMAS		2. DATE AND HOUR OF DEATH APRIL 11, 1971 11 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE MD.	
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MD. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		6. COUNTY 2302	
7. SEX F		8. RACE W		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY LEATHERITE CLEANERS		11. DATE OF BIRTH 2-6-28	
13. FATHER'S NAME WILLIAM CANBY		14. MOTHER'S MAIDEN NAME HELEN PITZINGER		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT HOSP CHART	
18. 20501		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		ACUTE GRANULOCYTIC LEUKEMIA		7 MO.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		CHRONIC GRANULOCYTIC LEUKEMIA		3 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from APRIL 6 19 71 to APRIL 11 19 71 that (H) (we) last saw the deceased alive on APRIL 11 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin J. Gordon M.D.		23B. DATE SIGNED 4/11/71		23C. PHYSICIAN'S NAME (Type) MARVIN J. GORDON M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Mc Gully Funeral Home 130 E. Fort Ave.	
24D. LOCATION (City, town, or county) A.A. County		24E. STATE Md.		25D. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 3563</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>HORSEMAN, MARVIN JR.</u>				2. DATE AND HOUR OF DEATH <u>4-11-71</u> <u>4³⁰ A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2404</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>163 E. Randall Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-13</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James G. Horseman</u>				14. MOTHER'S MAIDEN NAME <u>Lura Higgins</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Mildred K. Horseman</u>			ADDRESS <u>163 E. Randall Street</u>
18. CAUSE OF DEATH <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Heart Disease</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: ----- (C) -----			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -----	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -----			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -----		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -----			
22. I certify that (I) (this hospital) attended the deceased from <u>4-11</u> 19 <u>71</u> to <u>4-11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-11</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Surat Sinasa, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/11/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SURAT SINASA</u>				23D. ADDRESS <u>South Bal. Gen. Hosp., Baltimore Md 21230</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/14/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mc Cully Funeral Home 130 E. Fort Avenue</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3564	
BIRTH NO. K-400		1. NAME OF DECEASED (Type or Print) John W Koll			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00		2. DATE AND HOUR OF DEATH April 10, 1971			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 3114 Ferndale Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7-25-1894	
13. FATHER'S NAME Michael Koll		14. MOTHER'S MAIDEN NAME Wettig		9. AGE (In years lost birthday) 76	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown WW 1 Army		16. SOCIAL SECURITY NO. 213-34-0432		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Insufficiency (C) DUE TO, OR AS A CONSEQUENCE OF: Marked Arteriosclerosis Hypertension & CVD		12. CITIZEN OF WHAT COUNTRY? USA	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thor G Abbott				23B. DATE SIGNED 4-12-71	
23C. PHYSICIAN'S NAME (Type) Thomas G Abbott				23D. ADDRESS 4309 Liberty Hwy Etc	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1971			
25B. NAME OF FUNERAL DIRECTOR Arma cost		25C. FUNERAL DIRECTOR ADDRESS Funeral Chapel-4600 Liberty Hts			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

DWANE K. LITTLE

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2633

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Feb. 3, 1967

10. AGE (In years
lost birthday)

4

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3473 Mayfield Avenue

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles C. Little

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Georgia Ann Richter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

-

18. INFORMANT

Charles C. Little

ADDRESS

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

E963X

CAUSE OF DEATH

Strangulation

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

?

22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?

?

00-00

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) ??

22E. INJURY OCCURRED

WHILE AT
WORK ☐

?

NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Strangled

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/7/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-10-71

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial

24D. LOCATION

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John C. Miller Inc-415 Belair Rd.-21206

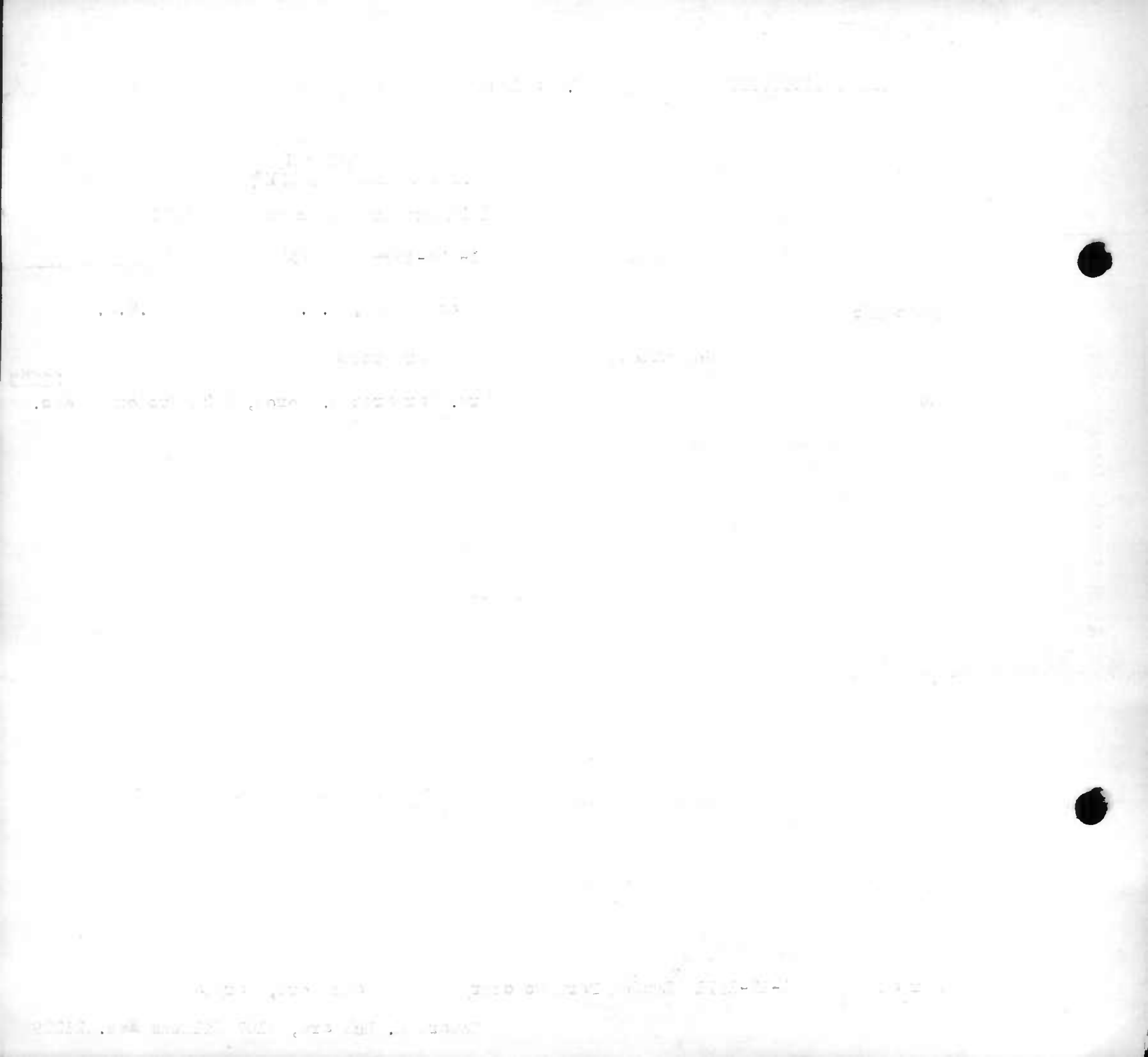
ADDRESS

ACADEMY OF MUSIC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

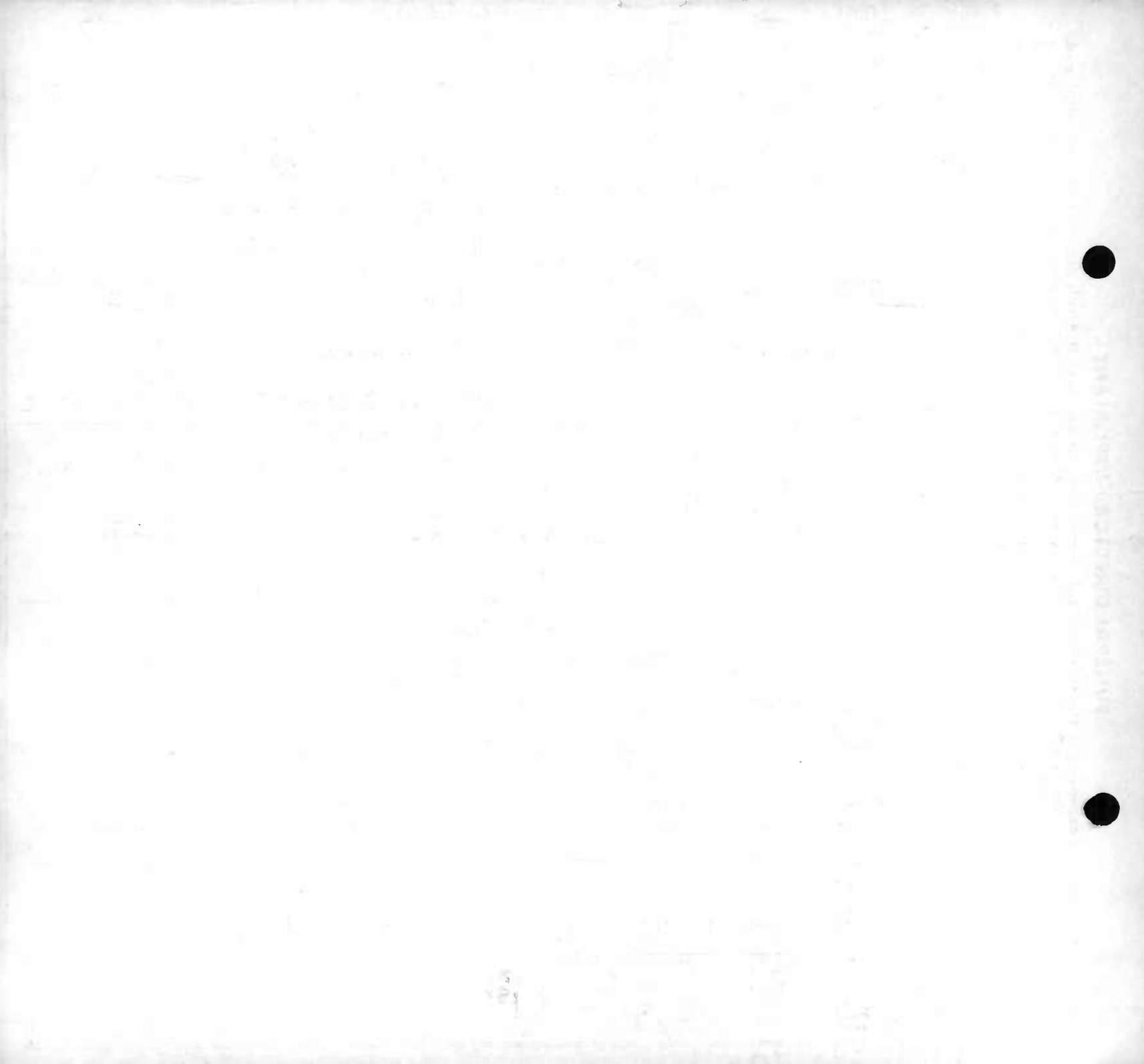
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
71 3566		71 3566		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 1-25		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) XXXXXXXXXXXX EMMA K. Davison		2. DATE AND HOUR OF DEATH 4/8/71 9:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Key Circle Hospice 901214 EUTAW PL.		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1703	
5. SEX FE 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-26-1886 9. AGE (in years last birthday) 85		10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sommerlott		14. MOTHER'S MAIDEN NAME Margaretta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-48-9757		17. INFORMANT ADDRESS Mrs. Margaret D. Doron, 1821 Frederick Ave. 21223	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Chronic Brain Syndrome			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4 8 71 9:45 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/7/70 to March 8 1971 that (I) (we) last saw the deceased alive on March 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dionisio Garcia Jr.		23B. DATE SIGNED 4/9/71			
23C. PHYSICIAN'S NAME (Type) DIONISIO GARCIA JR. M.D.		23D. ADDRESS 5550 - Falls Rd. - PIKE 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 13 1971		24F. NAME OF REGISTRAR John E. Taylor, R.D.	
24G. FUNERAL DIRECTOR Howard H. Hubbard		24H. ADDRESS 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

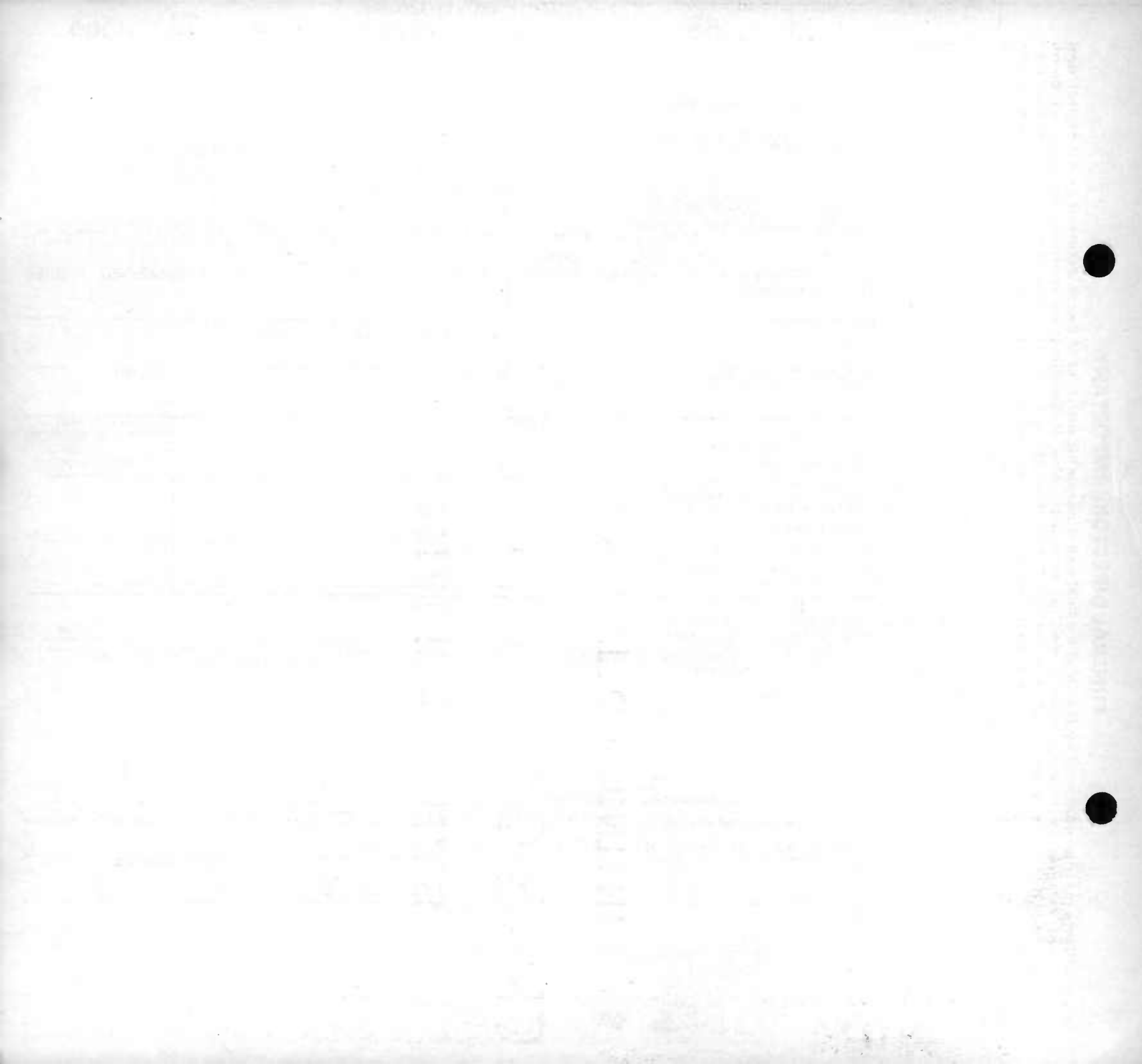
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>L-152</u> <u>71 3567</u>					REG. NO. <u>71 3567</u>				
1. NAME OF DECEASED (Type or Print) <u>Loving, Mary B.</u>					2. DATE AND HOUR OF DEATH <u>4/7/71</u> <u>1:30</u> P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>44 Union Memorial Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE</u> <u>5300</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>					C. CITY OR TOWN <u>Balto</u> <u>21228</u>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
					E. STREET AND NUMBER <u>114 Beaumont Ave</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-15-87</u>		9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>act. (?)</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>					14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>8</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Alma Derwort</u>			ADDRESS <u>same as above</u>	
18. <u>4/2/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>dehydration</u> <u>Cardio-Vasc. insuff</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> <u>old age</u>					CAUSE OF DEATH <u>dehydration</u> <u>Cardio-Vasc. insuff</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Yrs.</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>not known</u>									
19A. DATE OF OPERATION <u>4</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>None</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner <u>NO</u>)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> <u>1971</u> to <u>4/2</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>4/7</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Chas Fazeckas MD</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>4/7</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. FAZEKAS MD</u>					23D. ADDRESS <u>U. M. H.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4-10-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		
25A. DATE OF DEATH <u>APR 13 1971</u>			25B. NAME OF REGISTRAR <u>John E. Smith</u>		25C. FUNERAL DIRECTOR <u>John E. Smith</u>			ADDRESS <u>John E. Smith</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 3568</u>	
BIRTH NO. <u>C-200 71 3568</u>				1. NAME OF DECEASED (Type or Print) <u>Cash, Josephine</u>		2. DATE AND HOUR OF DEATH <u>4-12-71</u> <u>8:30 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1</u>		C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 So Balto Gen Hosp</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <u>14375 Honover St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Richard Stevens</u>			14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Records</u>		
18. <u>5-9011</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute myocardial infarction, bilateral</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>4-12-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-3</u> 19 <u>71</u> to <u>4-12</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-12</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Virginia Faust - Mercado M.D.</u>				23B. DATE SIGNED <u>4-12-71</u>		23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA F. MERCADO, M.D.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-15-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Pedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Covington Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Arritts F.H. Covington - Va.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

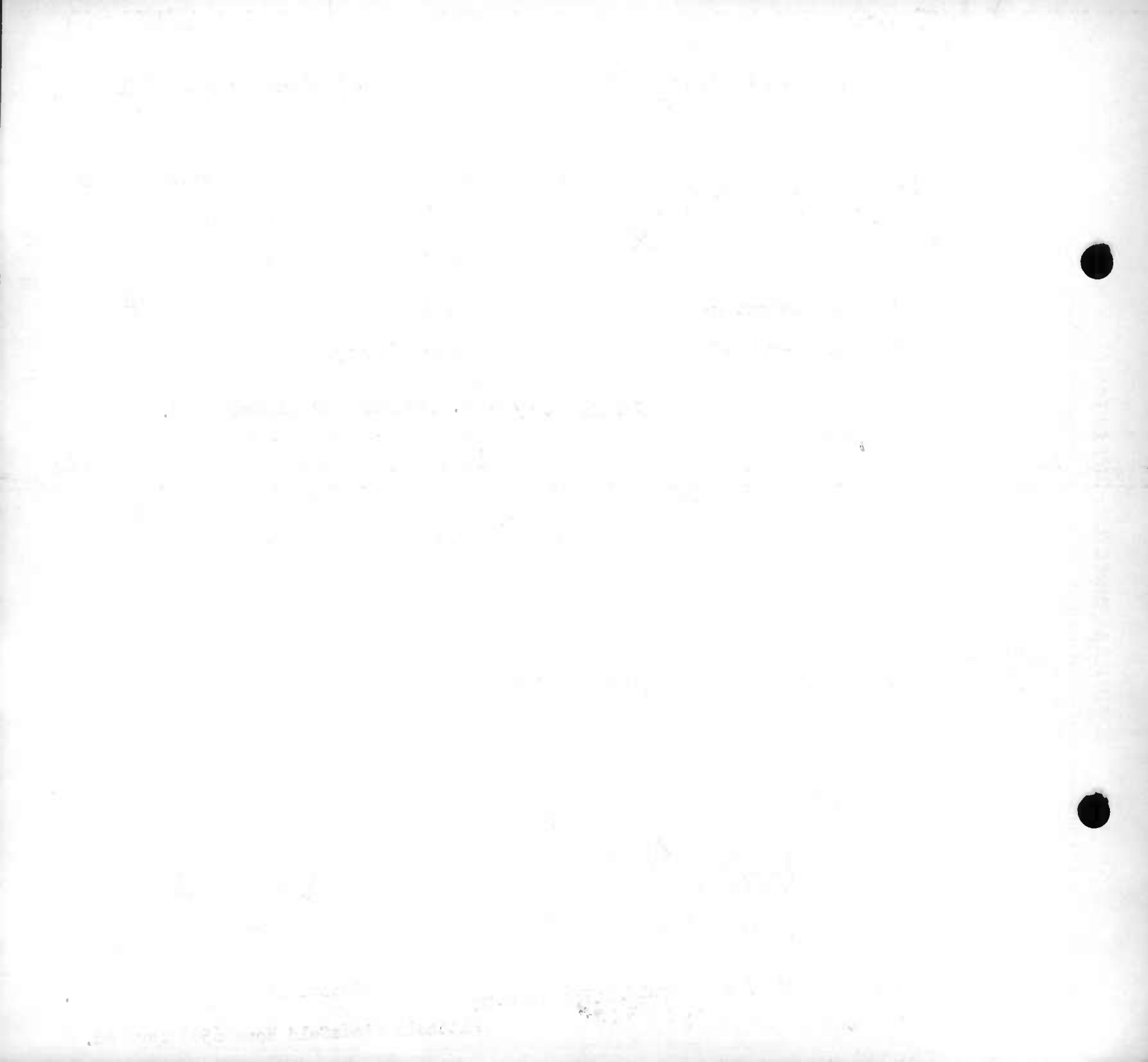
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3569	
BIRTH NO. N-631 1. NAME OF DECEASED (Type or Print) NORDHOFF, EDNA LOUISE		2. DATE AND HOUR OF DEATH APRIL 7, 1971 4:35A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1315 RIDGE RD. 21228 5300	
5. SEX FEMALE 6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 29 15 9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME CHARLES SHRILEY		14. MOTHER'S MAIDEN NAME HELEN (SUTTON)	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WILKENS AVES. BALTO. ST. AGNES HOSPITAL RECORDS - CATON &		ADDRESS MD. 21229	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1-5-4-1 I CARDIO RESPIRATORY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 DAYS. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) METASTATIC CA OF RECTUM 6 MONTHS. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4 - 7 '71 4:35	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3-28-1971 to 4-7-1971 that (X) (we) last saw the deceased alive on 4-6-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. Sabanyagam		23B. DATE SIGNED 4-7-71	
23C. PHYSICIAN'S NAME (Type) P. SABANYAGAM M.D.		23D. ADDRESS 21229 CATON & WILKENS AVES. BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/9/71	
24C. NAME of CEMETERY or CREMATORY LOUDAN PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR John E. [Signature]	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS 21228	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-253 71 3570		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	71 3570
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Townsend, Mary Elisabeth</u>		2. DATE AND HOUR OF DEATH <u>4/8/71 5:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		5. CITY OR TOWN <u>Towson, Md.</u> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>Baltimore, Md.</u>		E. STREET AND NUMBER <u>307 W. Pennsylvania</u>			
5. SEX <u>F.</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-25</u>	9. AGE in years (last birthday) <u>45</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lawrence Eustor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Green</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-20-3639</u>		17. INFORMANT ADDRESS <u>Wm S. Townsend 27 Lambourne Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>5771.01</u> [This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.]		CAUSE OF DEATH <u>Pneumonia bilobes</u> <u>Hepatic coma</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic alcoholism</u> <u>Feeding due to liver insuff</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 wks</u> <u>Yrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>Feb 1970, 3/14/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Vaginal bleeding</u>		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4/8</u> to <u>4/8</u> 19 <u>71</u> and that (2) (we) last saw the deceased alive on <u>4/8</u> 19 <u>71</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Charles F. Fizekas M.D.</u>		23B. DATE SIGNED <u>4/8/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. Fizekas M.D.</u>		23D. ADDRESS <u>U. M. H.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/10/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fizekas, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>		25D. ADDRESS <u>6500 York Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3571</u>	
<p>BIRTH NO. <u>0-300 71 3571</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Mrs Mary A. Owad</u></p>		<p>2. DATE AND HOUR OF DEATH <u>April 6, 1971</u> M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>817 Saint Paul Street</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1101</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>817 Saint Paul Street</u></p>			
<p>5. SEX <u>Female</u> 6. RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Sept. 8, 1886</u> 9. AGE (In years last birthday) <u>84</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Pehna</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>Simon Worrick</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>unknown</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO. <u>190-30-5492</u></p>		<p>17. INFORMANT <u>Miss Pauline Owad 817 St. Paul St</u> ADDRESS</p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebro-Vascular Accident</u></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cerebro-Vascular Disease</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>5 days</u></p>		<p>(C) _____</p>	
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>(If in Baltimore City, give exact location)</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR?</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>January 7th</u> 19 <u>70</u> to <u>April 6th</u> 19 <u>71</u>, that (I) <u>last</u> saw the deceased alive on <u>April 6th</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Philip D. Flynn</u></p>		<p>23B. DATE SIGNED <u>4/7/71</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>Philip D. Flynn, M.D.</u></p>	
<p>23D. ADDRESS <u>115 Chase St., Baltimore, Md., 21202</u></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>			
<p>24B. DATE <u>4/12/71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>St. Stephens</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Leisenring, Penna</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home 6500 York Rd.</u></p>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3572	
BIRTH NO. L-360		71 3572		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Miss Caroline T. Lyder			2. DATE AND HOUR OF DEATH April 6, 1971 12:20 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 KESWICH HOME FOR INCURABLES			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER & 700 W. 40th Street		
5. SEX female		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) social worker/teacher		10B. KIND OF BUSINESS OR INDUSTRY retired		8. DATE OF BIRTH 10/20/00	
13. FATHER'S NAME Mr. Jay W. Lyder		14. MOTHER'S MAIDEN NAME Grace Trimble		9. AGE (In years last birthday) 70 72 11. BIRTHPLACE (State or foreign country) Akron, Ohio	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-30-5122		17. INFORMANT Keswick records ADDRESS 700 W. 40th St.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 11 yrs. unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 23 Sep 19 63 to 6 Apr 19 71 that (I) (we) last saw the deceased alive on 6 Apr 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aubrey D. Richardson, MD				23B. DATE SIGNED 6 Apr 1971	
23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson, MD				23D. ADDRESS 700 W. 40th Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/71		24C. NAME OF CEMETERY OR CREMATORY Lakewood Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home ADDRESS 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-300 71 3573 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 71 3573	
1. NAME OF DECEASED (Type or Print) READ JOSEPH F.		2. DATE AND HOUR OF DEATH APRIL 7th 1971 - 9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE MD-21201		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Woodlawn D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1924 Greengage Road 21207	
5. SEX M	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator		10B. KIND OF BUSINESS OR INDUSTRY Baltimore Gas & Elec. Co.	9. AGE (In years last birthday) 47 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late Charles F. Read		14. MOTHER'S MAIDEN NAME Mary Alice Bradburn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 2/25/43-12/15/45		16. SOCIAL SECURITY NO. 215-16-5806	
17. INFORMANT University Hospital ADDRESS UNIVERSITY OF MD. HOSPITAL BALTIMORE MD-21201			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 4-7-71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) +	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-29-71 19 to 4-7-71 19 that (I) (we) last saw the deceased alive on 4-7-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE ROSTAN FARDIN M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ROSTAN FARDIN M.D.		23D. ADDRESS UNIVERSITY OF MD. HOSPITAL BALTIMORE MD-21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/12/71	24C. NAME OF CEMETERY or CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971	25B. NAME OF REGISTRAR Robert E. Fisher	25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Ave., 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3574		REG. NO. 71 3574	
BIRTH NO. B-620		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) BYERS, ELEANOR ANN				2. DATE AND HOUR OF DEATH APRIL 8, 1971 4:15A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY 21228	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 5509 SO. MEDWICK GARTH		2854	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04 16 26	9. AGE (in years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES E. O'NEILL				14. MOTHER'S MAIDEN NAME HELEN (MULRANEY)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 157167120		17. INFORMANT WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &			
18. 5-6-2-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH hypoxia Aspiration Septicemia, Peritonitis initial stenosis, Ruptured liver				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 3		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED diverticulitis		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from MARCH 21 19 71 to APRIL 8 19 71 that (X) (we) last saw the deceased alive on APRIL 8 19 71 and that in (Xy) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/71		24C. NAME OF CEMETERY or CREMATORY Beverly National Cemetery		24D. LOCATION (City, town, or county) (State) New Jersey	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave. Balto., Md 21228			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>71 3575</u></p>	
<p>BIRTH NO. <u>S-552</u></p>		<p>DATE AND HOUR OF DEATH <u>4. 11. 71</u> <u>7:00 a.m.</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>SIMMONS, WILLIAM CARELL</u></p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>3. PLACE OF BIRTH (If not in Baltimore, give street address or location) <u>USPHS Hospital, Baltimore Md.</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Md</u> B. COUNTY <u>Balto</u></p>	
<p>5. SEX <u>M</u> 6. RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>	
<p>8. DATE OF BIRTH <u>2.19.06</u></p>		<p>9. AGE (In years last birthday) <u>65</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>Maritime</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Va. USA</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>US</u></p>	
<p>13. FATHER'S NAME <u>Floyd Simmons</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Demby</u> Magie Carter</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWII</u></p>		<p>16. SOCIAL SECURITY NO. <u>551120561</u></p>	
<p>17. INFORMANT <u>Floyd Simmons</u></p>		<p>ADDRESS <u>3600 Brighton St. Portsmouth VA.</u></p>	
<p>18. CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BACTERIAL PNEUMONIA</u></p> <p>(B) CARCINOMA OF LUNG. DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>			
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): <u>PULMONAR EMPHYSEMA</u></p>			
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (H) (this hospital) attended the deceased from <u>9. 22. 70</u> to <u>4. 11. 71</u> that (H) (we) last saw the deceased alive on <u>4. 11. 71</u> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Frank Gross</u></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>FRANK GROSS</u></p>		<p>23D. ADDRESS <u>USPHS HOSP. Balto Md.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u></p>		<p>24B. DATE <u>4/11/71</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Beechwood Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Boykins Va.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>John E. Kelly JR.</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Loring Byers</u></p>		<p>ADDRESS <u>8728 Liberty Rd. Randallstown Md.</u></p>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3576	
C-234 71 3576		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Leo B. Costello		2. DATE AND HOUR OF DEATH April 11, 1971 3:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hosp. 5601 Loch Raven Blvd. Balto, Md. 21239		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Florida B. COUNTY V-08 C. CITY OR TOWN Fort Lauderdale D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4380 N.W. 35th Avenue	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/03 9. AGE (In years lost birthday) 67 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10B. KIND OF BUSINESS OR INDUSTRY EDUCATION	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry		14. MOTHER'S MAIDEN NAME Katherine Dailey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. 577X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Respiratory insufficiency 1 yr. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Interstitial pulmonary fibrosis 1 yr.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic pneumothorax		6-12 mo.	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-1-71 19 to 4-11-71 19, that (I) (we) last saw the deceased alive on 4-11-71 at 3:20 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Steve L. Johnson M.D.		23B. DATE SIGNED 4-11-71	
23C. PHYSICIAN'S NAME (Type) Steve L. Johnson, M.D.		23D. ADDRESS Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-15-71	24C. NAME OF CEMETERY or CREMATORY Moravian Cemetery	24D. LOCATION (City, town, or county) (State) Staten Island New York
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Johnson Funeral Home	
25C. FUNERAL DIRECTOR 8521		ADDRESS Loch Raven Blvd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1 ca

BIRTH NO. <u>M-260</u> <u>71-05578</u> <u>3577</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71</u> <u>3577</u> <u>Y</u>	
1. NAME OF DECEASED (Type or Print) <u>BABY BOY McCree</u>			2. DATE AND HOUR OF DEATH <u>4/3/71</u> <u>7:45 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			A. STATE <u>Maryland</u> B. COUNTY <u>808</u>		
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			E. STREET AND NUMBER <u>1124 McDonough St.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			8. DATE OF BIRTH <u>4/2/71</u> 9. AGE (In years last birthday) <u>21</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>Essie Jane Williams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>BCH RECORDS:</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			ADDRESS		
18. <u>778-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Distress Syndrome</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>112 hours</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prenatality</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Hemorrhage</u> (C) <u>Approx 3-4 hrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> 19 <u>71</u> to <u>4/3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Peter O. Knitter</u>			23B. DATE SIGNED <u>4/3/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Peter O. Knitter M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>			24B. DATE <u>April 5, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore City Hospital</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>			24E. ADDRESS <u>21224</u>		24F. FUNERAL HOME <u>HOSPITAL DISPOSAL</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>			25B. NAME OF REGISTRAR <u>John E. Kelley</u>		25C. FUNERAL HOME <u>HOSPITAL DISPOSAL</u>

Handwritten notes at the top of the page, including a checkmark and some illegible text.

Handwritten text in the middle section of the page.

Handwritten text in the middle section of the page.

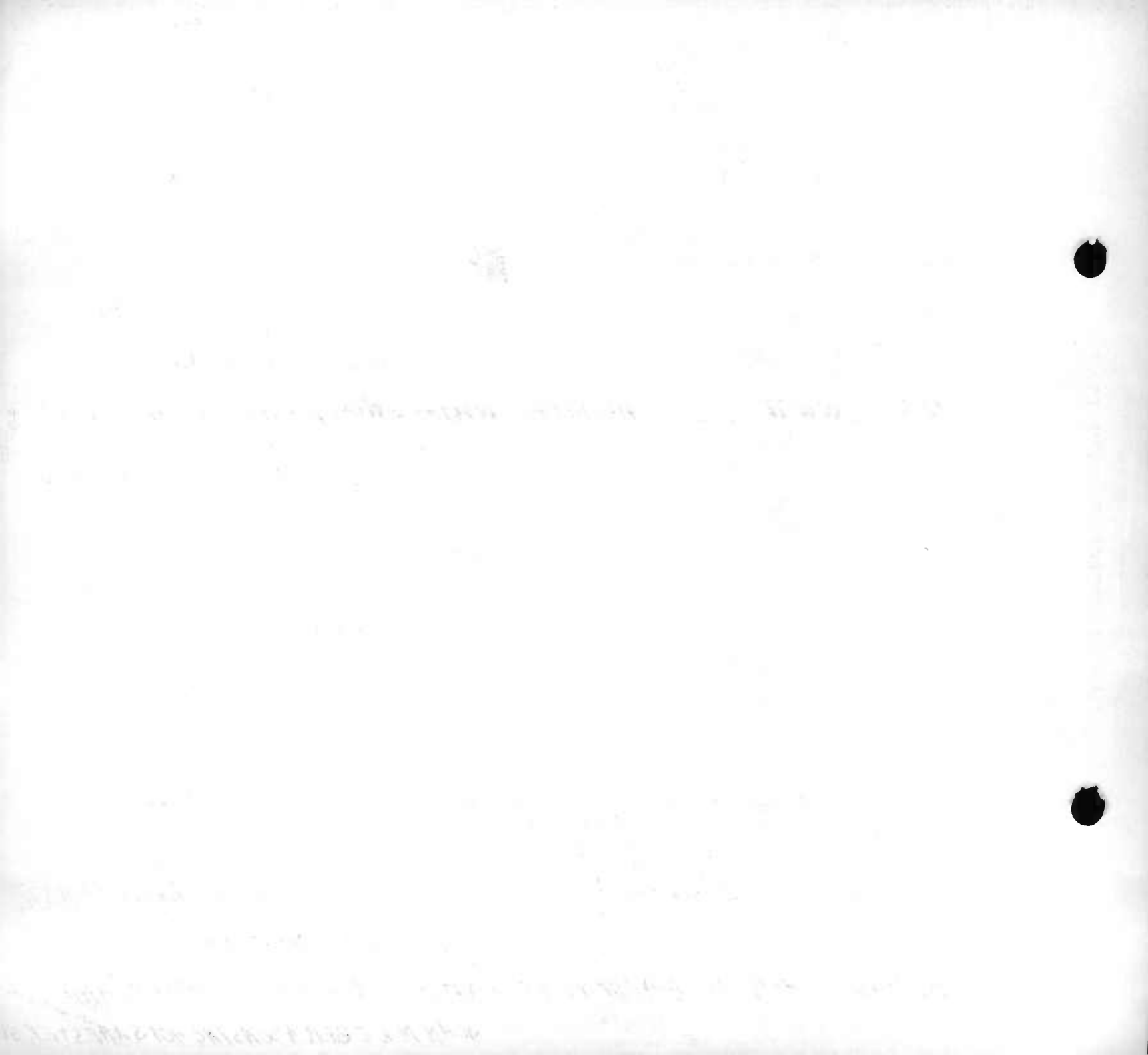
Handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page, including a checkmark and some illegible text.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

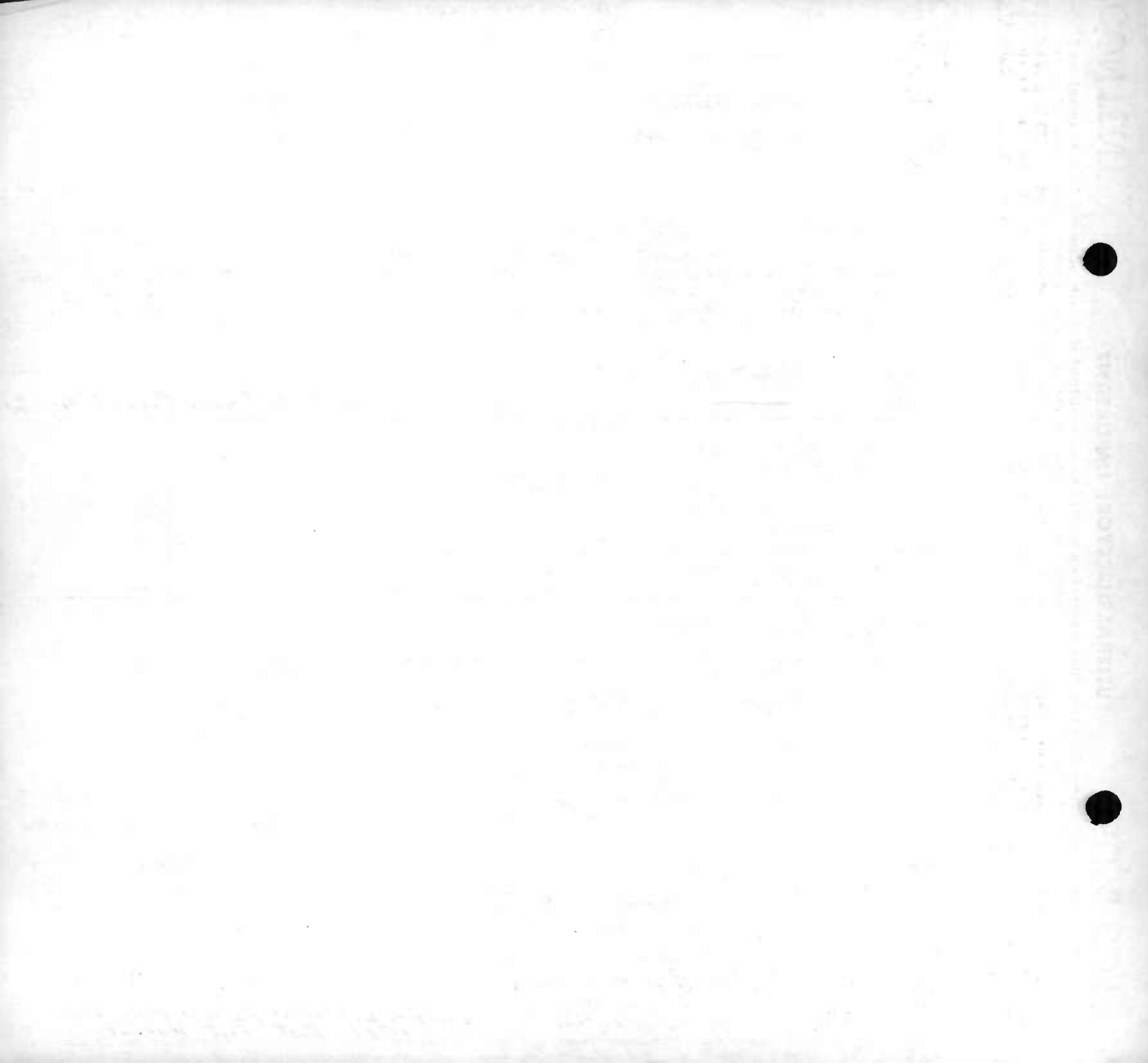
BALTIMORE CITY HEALTH DEPARTMENT				71 3578	
CERTIFICATE OF DEATH				REG. NO. 71 3578	
BIRTH NO. G-230 71 3578		1. NAME OF DECEASED (Type or Print) LEON GWIAZDA LEO JOHN			
2. DATE AND HOUR OF DEATH April 12, 1971 11 15 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 104		5. CITY OR TOWN Baltimore			
6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7. STREET AND NUMBER 507 S. Chester St			
8. SEX Male		9. RACE Caucasian		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. DATE OF BIRTH 6/28/18		12. AGE (In years last birthday) 52		13. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cann Cork & Seal		15. KIND OF BUSINESS OR INDUSTRY		16. BIRTHPLACE (State or foreign country) Maryland	
17. CITIZEN OF WHAT COUNTRY? USA		18. FATHER'S NAME Stanislaws		19. MOTHER'S MAIDEN NAME Josephine Jagiello	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		21. SOCIAL SECURITY NO. 218-01-0045		22. INFORMANT ADDRESS DOROTHY GWIAZDA 507 S. CHESTER ST	
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hodgkin's Disease		24. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hodgkin's Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Bronchitis		27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
28. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 7 19 71 to April 12 19 71 that (I) (we) last saw the deceased alive on April 12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Laurence Gills Jr MD 23C. PHYSICIAN'S NAME (Type) DEGREE		23B. DATE SIGNED April 12, 1971 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input checked="" type="checkbox"/>		23D. ADDRESS UNIVERSITY HOSPITAL DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-16-71		24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	
24D. LOCATION (City, town, or county) BALTO		24E. LOCATION (State) MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 13 1971	
25B. NAME OF REGISTRAR John M. Auer		25C. FUNERAL DIRECTOR JOHN M. AUER & SONS INC		25D. ADDRESS 401 S. CHESTER ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3579	
<div style="display: flex; justify-content: space-between;"> M 71 3579 71 3579 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Miller, Samuel T.</u>			2. DATE AND HOUR OF DEATH <u>4/11/71 @ 3:40pm</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balt. Gen. Hosp.</u>			A. STATE <u>Maryland</u>		
			B. COUNTY <u>2303</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator operator</u>			C. CITY OR TOWN <u>Baltimore, Md. 21230</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6 E. BARNEY ST.</u>		
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-98</u>	9. AGE (in years last birthday) <u>73</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY <u>Merchandise Store Deposit and Trust Co.</u>			11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>Greensburg Miller (dec)</u>			14. MOTHER'S MAIDEN NAME <u>Lewisia Maddox (dec)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-03-5929-A</u>		17. INFORMANT <u>Charts - South Baltimore General Hospital</u>
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cholera undeterminated</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Malnutrition - Mass occupancy in R. apartment</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>(malignancy) Anemia - Poss. Myocardial infarction</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No!</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-16-</u> 19 <u>71</u> to <u>4-11-</u> 19 <u>71</u> and that (I) (we) lost saw the deceased alive on <u>4-11-</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nedeljko Matesic</u>			23B. DATE SIGNED <u>4-11-71</u>		23C. PHYSICIAN'S NAME (Type) <u>NEDELJKO MATESIC</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/14/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>
24D. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u>		
25D. ADDRESS <u>1501 East Fort Avenue</u>					



1
Z 360

71 3580

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3580

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Doris May Zeider

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
Day
Year4
12
71

Hour

7:45 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If deceased died in a hospital, give name of hospital or institution)
ADDRESS OR LOCATION

Bon Secours Hospital

3. DATE
PRONOUNCED DEADMonth
Day
Year4
12
71

Hour

7:45 a. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

2001

6. SEX

female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 22 1939

10. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1936 W. Baltimore St.

11. BIRTHPLACE (State or foreign country)

Halifax, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lee Hipkins

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

house wife

14B. KIND OF BUSINESS OR INDUSTRY

home

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

231-26-9813

18. INFORMANT

sister - Mrs. Will. 1939 W. Baltimore St.

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Subdural hematoma

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty metamorphosis of liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☒ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

unknown Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

unk. 1936 W. Baltimore St.

22D. TIME
OF INJURY
(APPROX.)

unk. Apr. 1971

22E. INJURY OCCURRED
WHILE AT
WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

unknown Subject apparently fell
during epileptic seizure

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/12/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-14-71

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

24D. LOCATION (City, town, or county)

Glen Burnie Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1971

25B. NAME OF REGISTRAR

R. E. Jaber, M.D.

25C. FUNERAL DIRECTOR

G. L. Schwab

ADDRESS

2101 Fredrick Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 3581

BIRTH NO. 71 3581		2. DATE AND HOUR OF DEATH April 9, 1971 12:10 A.	
1. NAME OF DECEASED (Type or Print) CHARLES EDWARD BUSH		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1304	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Good Samaritan Hospital FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1900 9. AGE (In years, months, and days) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distribution Clerk		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY U. S. Tres. Dept.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Bush		14. MOTHER'S MAIDEN NAME Emmaline Peterson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213037771	
17. INFORMANT Aurelia Bush		ADDRESS 3432 1/2 Auchentoroly Terrace	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days 10 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from April 2, 1971 to April 9, 1971, that (X) (we) last saw the deceased alive on April 9, 1971 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael Colvin, M.D.		23B. DATE SIGNED April 9, 1971	
23C. PHYSICIAN'S NAME (Type) Michael Colvin, M.D.		23D. ADDRESS Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-71	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			

BY ORDER,

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

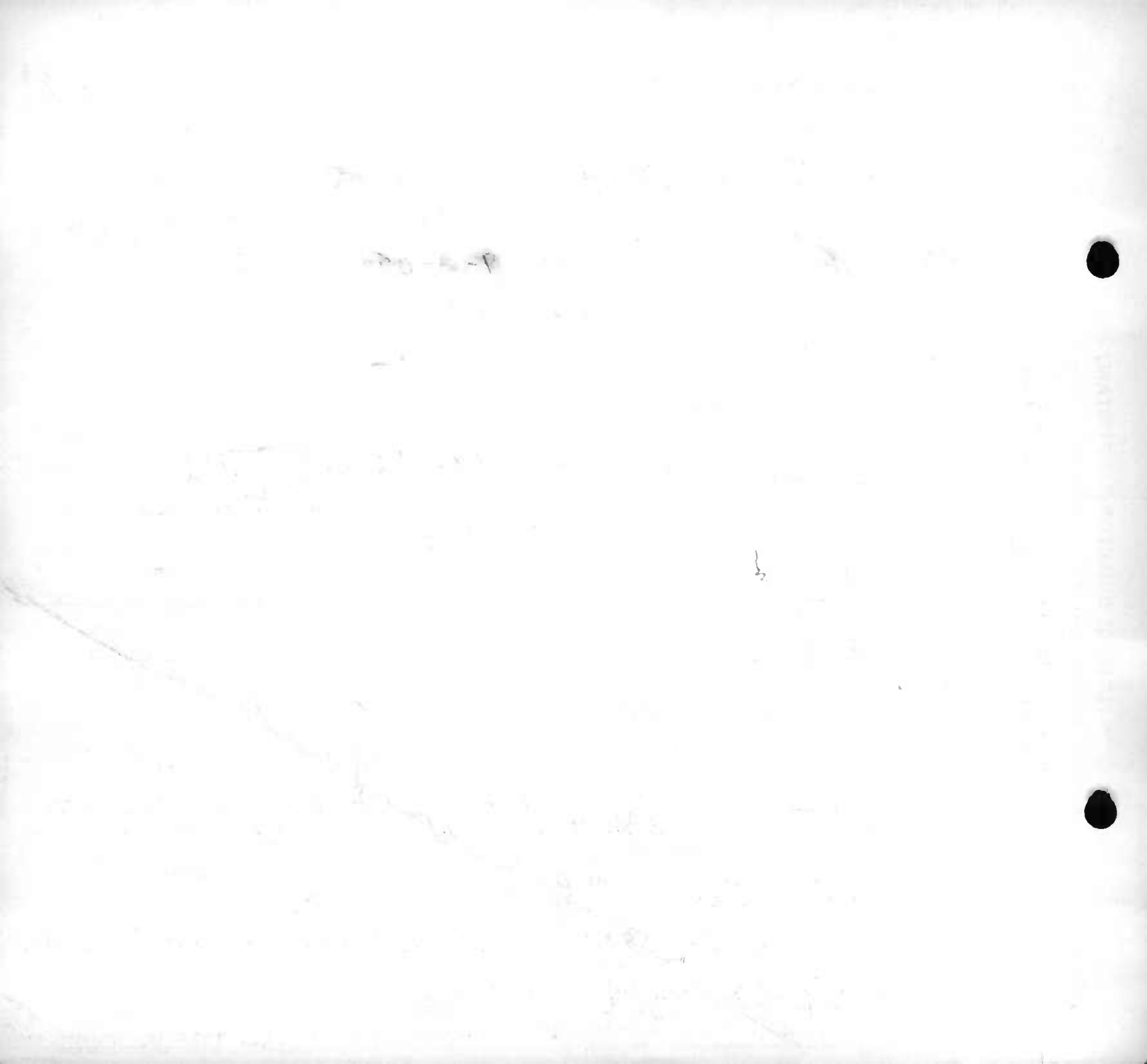
REG. NO.

1. NAME OF DECEASED (Type or Print) THOMAS S. SMITH JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3906 Dorchester Road		3. DATE PRONOUNCED DEAD Month Day Year April 7, 1971 Hour M. 7:25 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-28-1900		10. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman		14B. KIND OF BUSINESS OR INDUSTRY Shipping	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 711-16-2022	
13. FATHER'S NAME Sandy Smith		15. MOTHER'S MAIDEN NAME Mary Freeman	
18. INFORMANT Joseph P. Smith		ADDRESS 2101 Bryant Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 4-10-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) April 7, 1971		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-1971	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 3583		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 3583	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CAMPBELL, Henry T.		2. DATE AND HOUR OF DEATH 4-9-71		5³⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 1503		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2431-W. North Ave - 21216			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-05	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager		10B. KIND OF BUSINESS OR INDUSTRY Insurance Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William T. Campbell		14. MOTHER'S MAIDEN NAME Julia Butler					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. 215-10-1811		17. INFORMANT ADDRESS Edith D. Campbell 2431 W. North Ave.			
18. 7-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk duration			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-8-71 to 4-9-71 that (I) (we) last saw the deceased alive on 5³⁰ PM 4-9-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Okja Kim M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) OK JA Kim M.D.		23D. ADDRESS 730 Ashburton St. Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Gabley M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			



1

W-252 71 3584 BALTIMORE CITY HEALTH DEPARTMENT 71 3584

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) ARNETT WASHINGTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 9 1971 5:05 P.M.	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 8 1906		10. AGE (in years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTH PLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Home Security		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give wdr or dates of service) Yes		17. SOCIAL SECURITY NO.	
15. FATHER'S NAME Joseph C. Washington		15. MOTHER'S MAIDEN NAME	
18. INFORMANT Mrs. Margaret Washington		ADDRESS 1915 N. Monroe St.	
CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/10/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-71	
24C. NAME OF CEMETERY or CREMATORY Arbiter's Green Park		24D. LOCATION (City, town, or county) (State) Arbiter's Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Joseph L. Davis		ADDRESS 2222 W. North Ave.	

VS 151-REV. 1/1/68

1000

1000

Copy to
The Project Gutenberg
Library

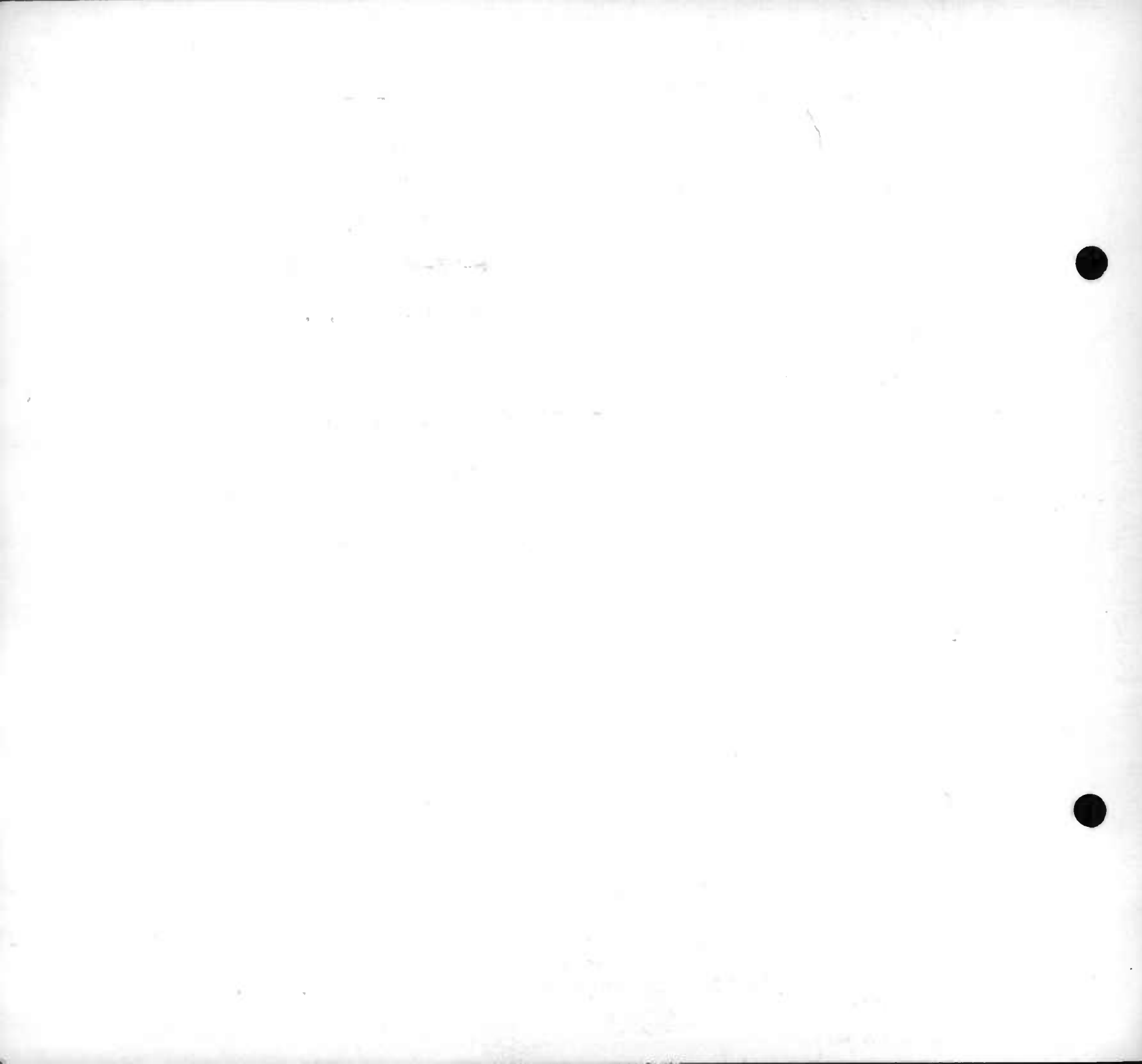
Project Gutenberg
Library

Project Gutenberg
Library

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3585</u>	
1. NAME OF DECEASED (Type or Print) <u>GLOVER MUNGO</u>		2. DATE AND HOUR OF DEATH <u>4-11-71</u> <u>2:05</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>B OLTON HILL NURSING CENTER</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> 8. COUNTY <u>909</u>			
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>5-23-42</u>	
13. FATHER'S NAME <u>Coleman Mungo</u>		14. MOTHER'S MAIDEN NAME <u>Mable</u>		9. AGE (In years last birthday) <u>28</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>247-74-4823</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland S.C.</u>	
17. INFORMANT <u>ADMISSION RECORD</u>		ADDRESS		12. CITIZEN OF WHAT COUNTRY	
18. <u>430.71</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3/26/71</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> 19 <u>71</u> to <u>4/11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/11</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>4/13/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>		23D. ADDRESS <u>2 E Red St Balto Md 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>William C. March</u>			
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>7-634 71 3586 CERTIFICATE OF DEATH REG. NO. 71 3586</p>	
<p>BIRTH NO.</p>	
<p>1. NAME OF DECEASED (Type or Print) FRETWELL, THORNTON S.</p>	
<p>2. DATE AND HOUR OF DEATH 4/12/71 12.55 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2710</p>	
<p>5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER 4414 WARMWOOD AVE</p>	
<p>6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE INC.</p>	
<p>5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH 9-1-99 9. AGE (In years last birthday) 71 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? RETIRED - PARISIER'S BAKERY BALTO. MD U.S.A</p>	
<p>13. FATHER'S NAME CARROLL FRETWELL 14. MOTHER'S MAIDEN NAME FLORENCE HARRYMAN</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS YES W W I 216-07-8324 MRS. THORNTON S. FRETWELL (same)</p>	
<p>18. CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>	
<p>(A) IMMEDIATE CAUSE RUPTURED ABDOMINAL AORTA DUE TO, OR AS A CONSEQUENCE OF: ANEURYSM</p>	
<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 4/12/71 P.O.B.R. No Yes</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>22. I certify that (1) (this hospital) attended the deceased from 4-12-71 to 4-12-71 that (2) (we) last saw the deceased alive on 4-12-71 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS SAHACHAI MUKASHUNHA SINAI HOSPITAL OF BALTIMORE</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State) Burial 4-15-71 Lake View Cemetery Baltimore, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS APR 13 1971 Robert E. Fisher, M.D. H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212</p>	

15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

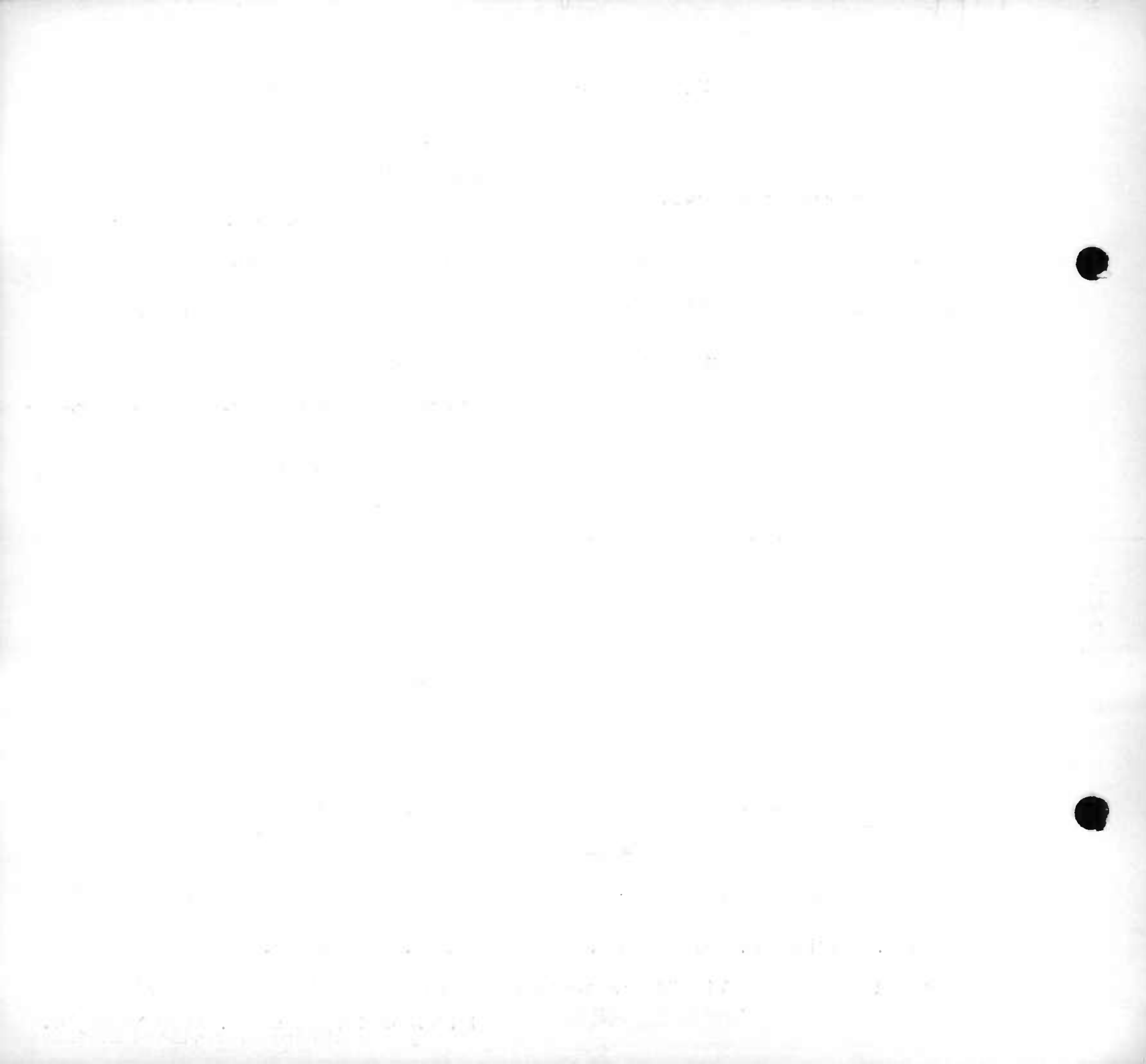
BALTIMORE CITY HEALTH DEPARTMENT									
71 3587 CERTIFICATE OF DEATH					REG. NO. 71 3587				
BIRTH NO. 7-433		1. NAME OF DECEASED (Type or Print) Fletcher, Frederic A. (Sr.)			2. DATE AND HOUR OF DEATH 4/10/71 7:15 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hudson Memorial Hospital 33rd Calvert St. Balto.					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1201 C. CITY OR TOWN Balto 21210 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 225 Stony Run Lane				
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/14/1882	9. AGE (In years last birthday) 88	11. Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect			10B. KIND OF BUSINESS OR INDUSTRY Fletcher & Co. Mass.		11. BIRTHPLACE (State or foreign country) Mass.			12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Fletcher +					14. MOTHER'S MAIDEN NAME REANN Christine Fletcher +				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO. HHI		17. INFORMANT Mrs. Hildegarde Fletcher (Same)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Left ventricular failure (pulm. edema) L-I bleeding metastasis to lung + spine Cancer of lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 2 wks 4 mos.				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). AB CVS									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4/10/71 to 4/10/71 that (I) (we) last saw the deceased alive on 4/10/71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Chester Fazeke MD					23B. DATE SIGNED 4/10/71			23C. PHYSICIAN'S NAME (Type) C. FAZEKAS MD	
23D. ADDRESS U. M. H.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-71		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, MD			25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, Md. 21212				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3588</u>
BIRTH NO. <u>R-200</u>				
1. NAME OF DECEASED (Type or Print) <u>Doris P. Roche</u>		2. DATE AND HOUR OF DEATH <u>4-11-71</u> <u>1:30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2606 Evergreen Ave.</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2706</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2606 Evergreen Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-22</u>	9. AGE (In years last birthday) <u>48</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mannas Beauty Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Kitzmuller</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clinton John Roche, Jr.</u>
				ADDRESS <u>4206 Bayonne Ave</u>
18. <u>4-10-71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Coronary Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Known Coronary disease 2 yrs.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1971</u> to <u>April 12, 1971</u> that (I) (we) last saw the deceased alive on <u>3-30-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>W.P. Benson, Jr.</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-12-71</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. William P. Benson, Jr.</u>		23D. ADDRESS <u>3502 N. Calvert St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>4-14-71</u>	24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME of REGISTRAR <u>J. E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u>
				ADDRESS <u>4905 York Rd. Baltimore, Maryland 21212</u>



FUNERAL DIRECTOR: IMPORTANT

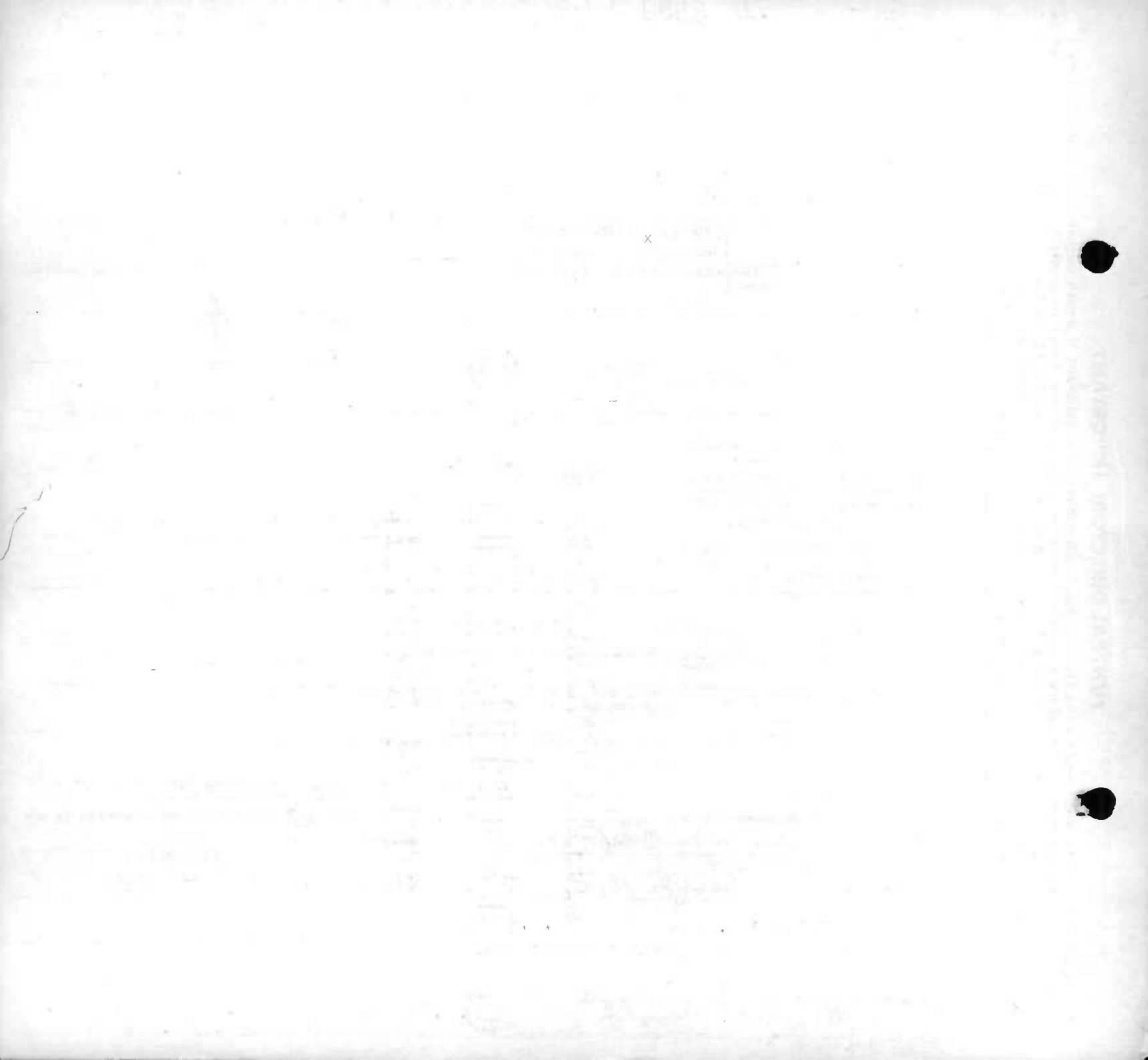
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3589</u>
BIRTH NO. <u>0-540</u>		71 3589 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>THOMAS M. O'NEILL</u>		2. DATE AND HOUR OF DEATH <u>APRIL 12, 1971 8:35 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSP.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1201</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4209 Tuscany CT.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-04</u>	9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COLUMNIST</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER-SUN</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN O'NEILL</u>		
14. MOTHER'S MAIDEN NAME <u>AGNES JENNINGS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>263-03-2763A</u>		17. INFORMANT <u>MAS JOLANDO D. O'NEILL</u>		
18. CAUSE OF DEATH <u>1621 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>1 APR</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I certify that (X) (this hospital) attended the deceased from <u>APRIL 8</u> 19 <u>71</u> to <u>APRIL 12</u> 19 <u>71</u> that (I) (yes) last saw the deceased alive on <u>APRIL 12</u> 19 <u>71</u> and that in (my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Lester A. Reid, M.D.</u>		23B. DATE SIGNED <u>4/12/71</u>		23C. PHYSICIAN'S NAME (Type) <u>LESTER A. REID, M.D.</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		
25D. ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-425				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 3590	
1. NAME OF DECEASED (Type or Print) <u>Clarence D. Wilson</u>				2. DATE AND HOUR OF DEATH <u>4/10/71</u> <u>6:14</u> <u>A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>907</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>				6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>07-22-98</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Landscape</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Bender Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN WILSON</u>				14. MOTHER'S MAIDEN NAME <u>SARAH CONLEY</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-12-5472</u>		17. INFORMANT <u>Clarence Wm. Wilson</u>		ADDRESS <u>7038 Heathfield Rd.</u>	
18. <u>5-19-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Severe Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Severe COPD + Pneumonia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>2 weeks</u> <u>2 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Renal Failure</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>4/1/71</u> 19 <u>71</u> to <u>4/10</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Richard L. Taw Jr. MD</u>				23B. DATE SIGNED <u>4/10/71</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD L. TAW</u> <u>M.D.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-13-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Parkville</u> <u>Maryland</u>	
25A. DATE RECD BY HEALTH DEPT. <u>APR 13 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u> <u>4905 York Rd.</u> <u>Baltimore, Md.</u> <u>21212</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

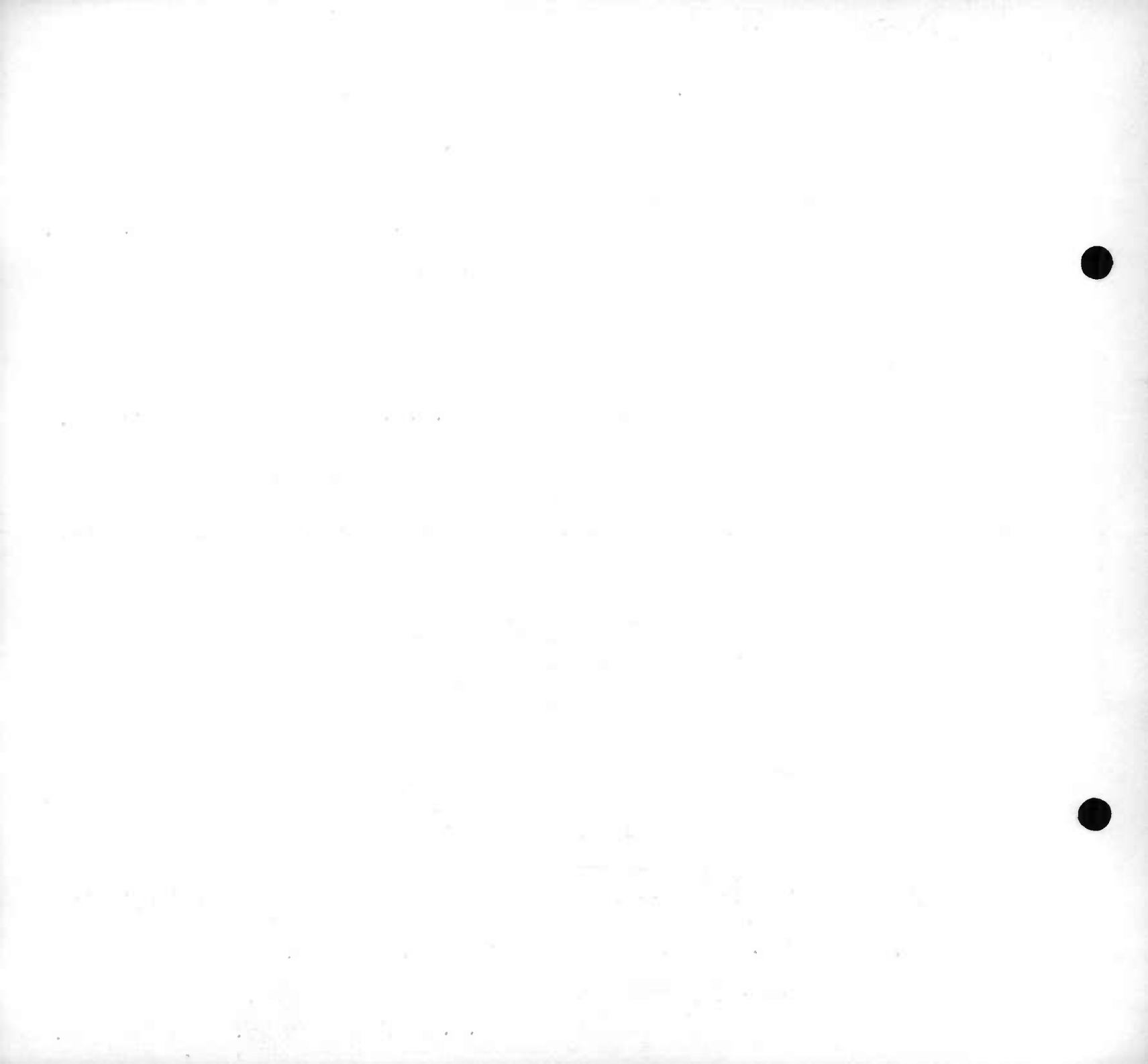
BIRTH NO. G-426		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3591	
1. NAME OF DECEASED (Type or Print) Mary R. Gallagher			2. DATE AND HOUR OF DEATH 4-7-71 9:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 104004 Linkwood Rd. Apt. C			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1201		
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Ret. Reg. Nurse			10B. KIND OF BUSINESS OR INDUSTRY St. Agnes Hosp.		8. DATE OF BIRTH 10-28-1892
13. FATHER'S NAME Gallagher			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-30-6684		9. AGE (In years last birthday) 78
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(B) Hypertensive H-SCVD DUE TO, OR AS A CONSEQUENCE OF: ? yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C)		
19A. DATE OF OPERATION 4/10/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/22/46 19 to 4/7/71 19 that (I) (we) last saw the deceased alive on 4/7/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis W. Gluck			23B. DATE SIGNED 4/10/71		23C. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-12-71		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971			25B. NAME OF REGISTRAR Robert E. Farley, Jr.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.			25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3592		
CERTIFICATE OF DEATH						
BIRTH NO. D-520		71 3592		1. NAME OF DECEASED (Type or Print) Fredericka K. Downs		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital			2. DATE AND HOUR OF DEATH 4-8-71 9 40 P.M.			
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Own Home		8. DATE OF BIRTH 6-15-88	
13. FATHER'S NAME Louis Marks			14. MOTHER'S MAIDEN NAME Louisa Schide		9. AGE (In years last birthday) 82	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 2-09-1153 B		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction			12. CITIZEN OF WHAT COUNTRY? USA		17. INFORMANT Mr. R.L. Downs	
19. DATE OF OPERATION 4/10/71			20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 4/8/71			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/24/71 to 4/8/71 that (I) (we) last saw the deceased alive on 2/10/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Dr. William F. Renner			23B. DATE SIGNED 4/9/71		23C. PHYSICIAN'S NAME (Type) Dr. William F. Renner	
24A. BURIAL, CREMATION, REMOVAL (Specify) Entombment			24B. DATE 4-12-71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.	
26A. ADDRESS 3222 St. Paul St.			26B. ADDRESS 4905 York Rd.		26C. ADDRESS Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

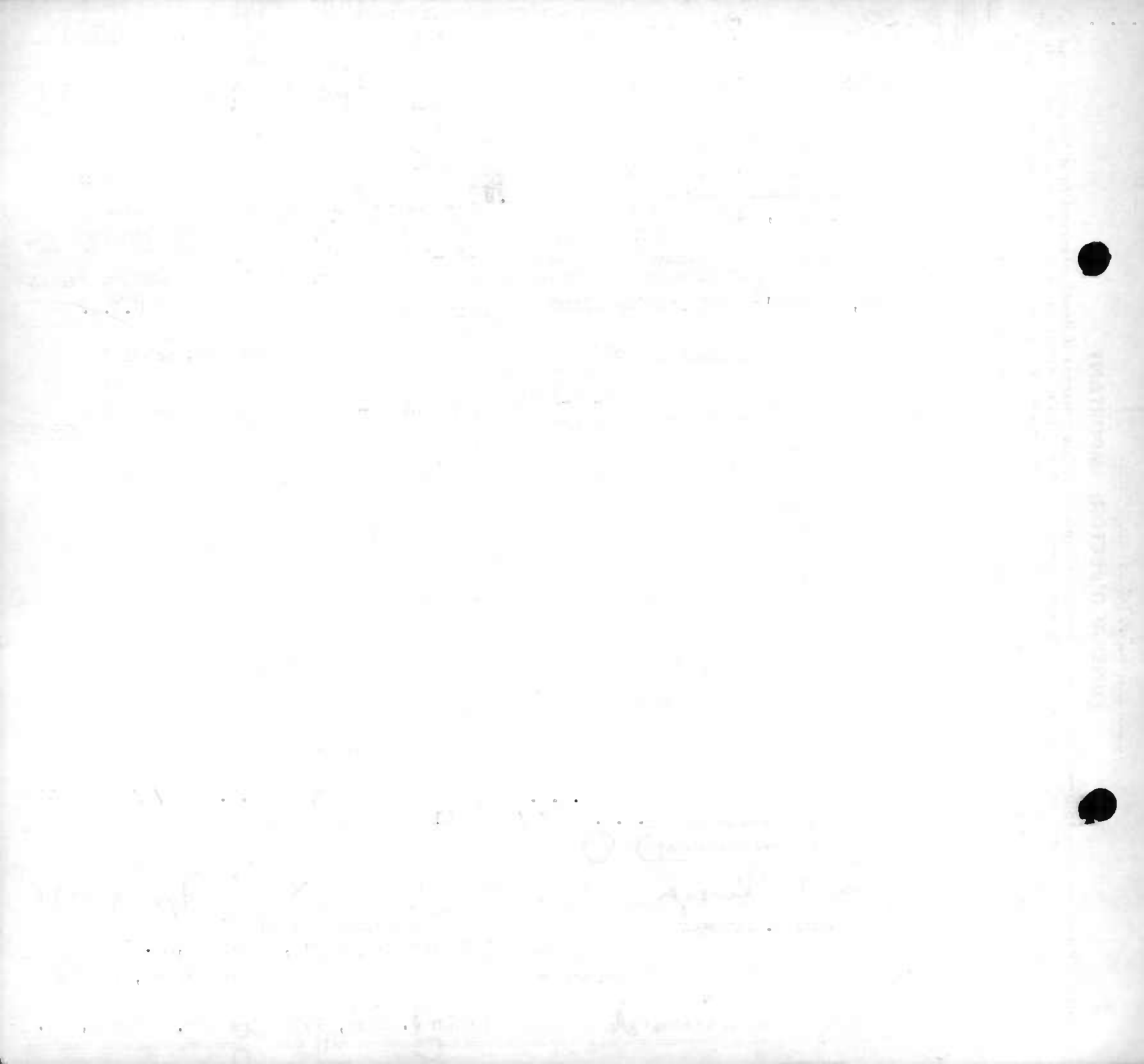
BIRTH NO. <u>U-460</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3593</u>	
1. NAME OF DECEASED (Type or Print) <u>Beulah Uhler</u>				2. DATE AND HOUR OF DEATH <u>4-7-71</u> <u>1 15 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>1209 St. Paul St.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1101</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1209 St. Paul St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11-1893</u>	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfield Center, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Orlando Williams</u>				14. MOTHER'S MAIDEN NAME <u>Drucilla ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-01-5464</u>		17. INFORMANT <u>William P. Uhler</u>		ADDRESS <u>Same</u>	
18. <u>437.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Anterior ilium, cerebral</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Rheumatoid arthritis</u> <u>Osteoporosis, spine</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u> <u>37 yrs. 1 year</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 28</u> 19 <u>65</u> to <u>present</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Harry F. Klinefelter</u>				23B. DATE SIGNED <u>April 8, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Harry F. Klinefelter</u>	
23D. ADDRESS <u>550 N. Broadway</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4-10-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		24D. LOCATION (City, town, or county) <u>Pikesville,</u>		24E. STATE <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u>		ADDRESS <u>4905 York Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

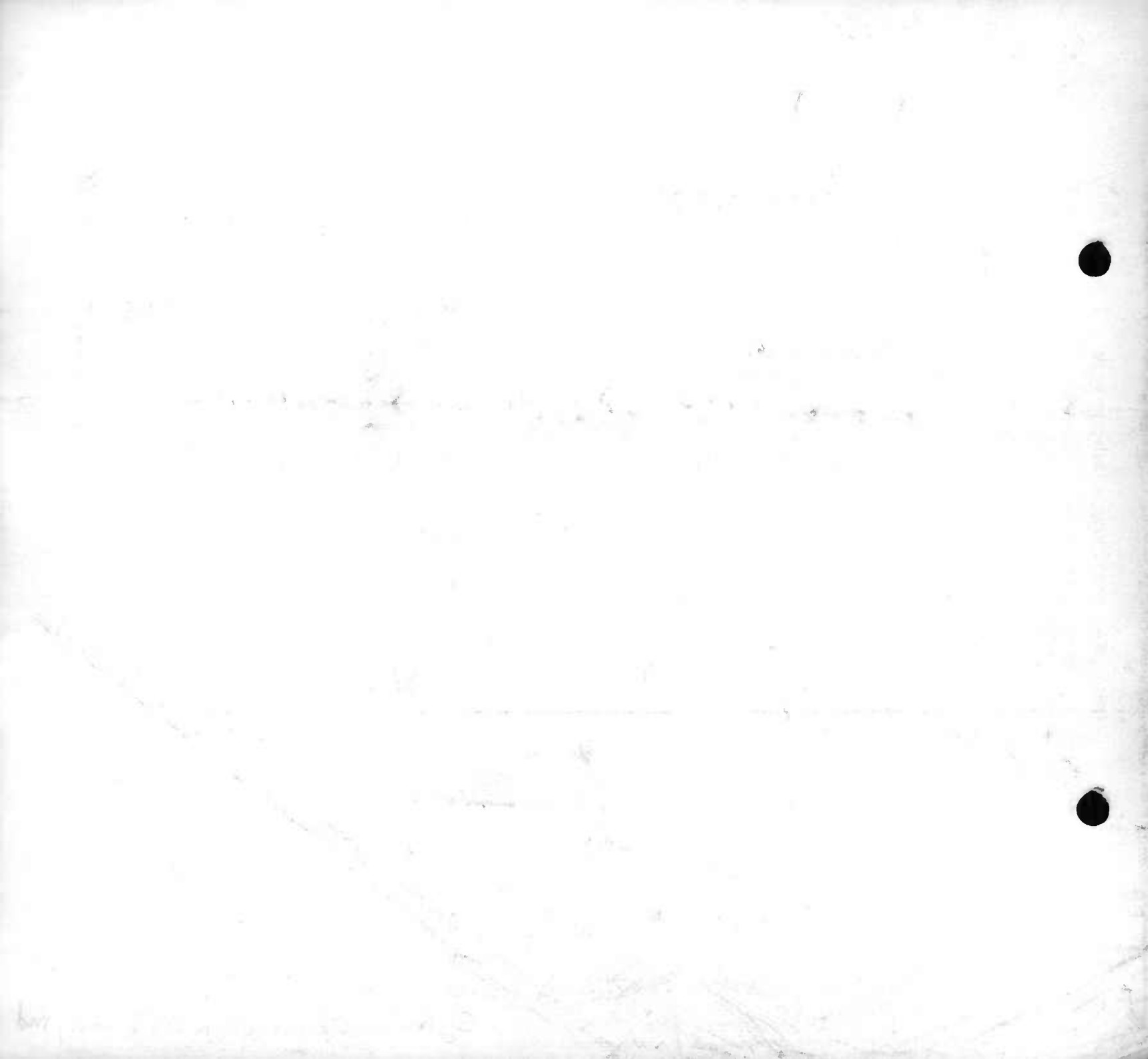
BIRTH NO. B-430		1. NAME OF DECEASED (Type or Print) Frederick Nicholas Bold		2. DATE AND HOUR OF DEATH April 9, 1971 12:35A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lead Man, Esskay's Meat Packing Plant			8. DATE OF BIRTH 8-15-1918		9. AGE (In years last birthday) 52 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nicholas Bold			14. MOTHER'S MAIDEN NAME Margaret Schmidt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			16. SOCIAL SECURITY NO. 217-09-0024		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE ? Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
MEDICAL CERTIFICATION			20A. AUTOPSY? (Yes or No) NO		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from D.O.A. Apr 9 1971 to D.O.A. 4/9/ 1971 that (1) (we) last saw the deceased alive on D.O.A. 4/9/ 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ross T. Krueger			23B. DATE SIGNED Apr 9, 1971		23C. PHYSICIAN'S NAME (Type) Ross T. Krueger
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			23E. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/13/71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer
24D. LOCATION Baltimore, Maryland			24E. DATE REC'D BY HEALTH DEPT. APR 13 1971		
24F. NAME OF REGISTRAR Robert E. Sabin, M.D.			24G. NAME OF REGISTRAR John J. Duda		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

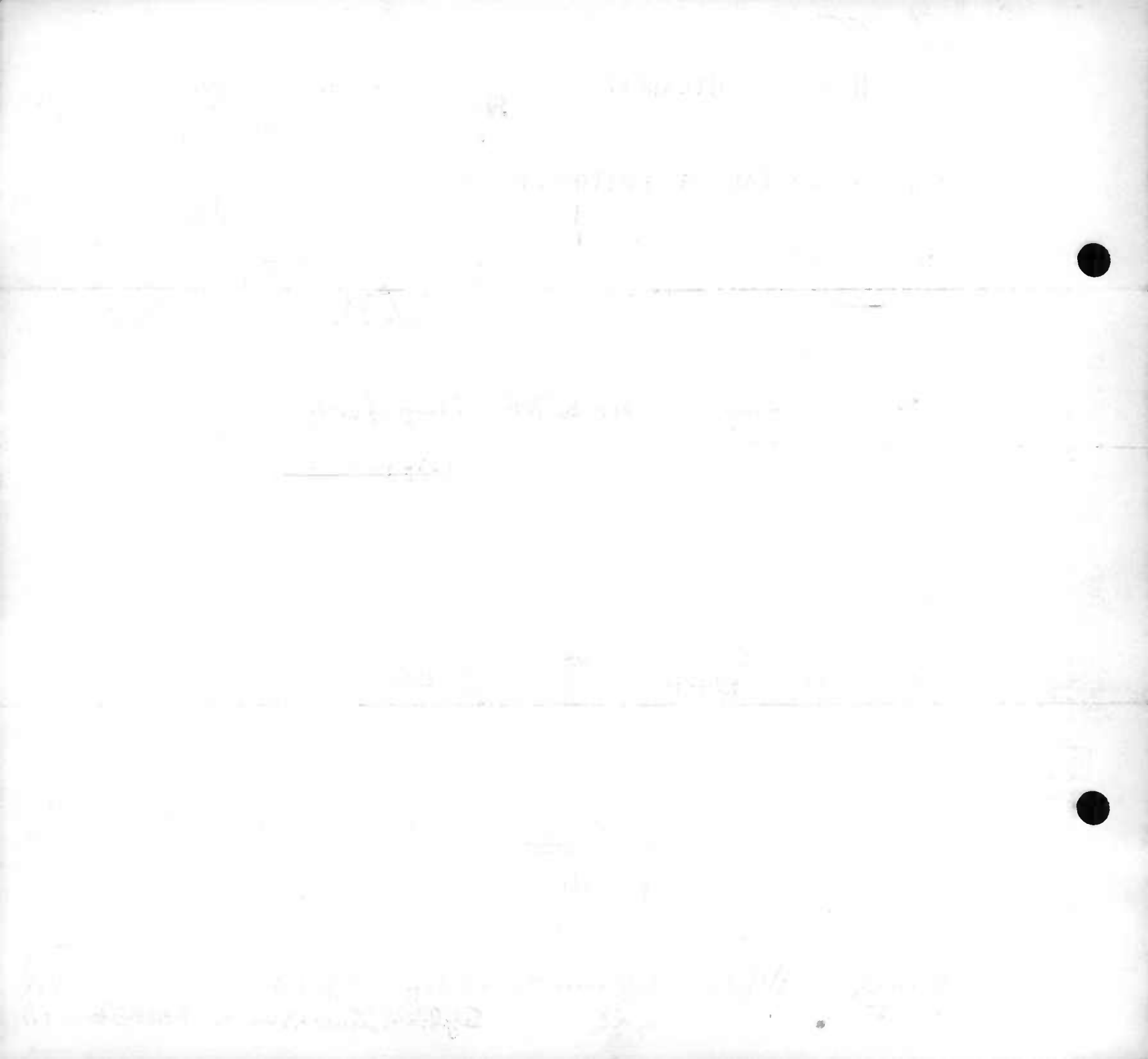
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3595</u>	
G-651		71 3595		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GRUMBERG, Josef</u>		2. DATE AND HOUR OF DEATH <u>April 10, 1971 10:05 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp</u>		C. CITY OR TOWN <u>Baltimore, Md</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>9-22-22</u>	
13. FATHER'S NAME <u>men</u>		14. MOTHER'S MAIDEN NAME <u>Betty</u>		9. AGE (In years last birthday) <u>48</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-546752</u>		17. INFORMANT <u>Hosp chart</u>	
18. <u>1971</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Cancer</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Widespread Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Origin not known</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>Oct 1, 1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>abdomen & rectum</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-10-71 10:05 P.M.</u> 19 <u>71</u> to <u>4-10-71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-10-71 10:05 P.M.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Antonio Ong, M.D.</u>		23B. DATE SIGNED <u>4-10-71</u>		23C. PHYSICIAN'S NAME (Type) <u>ANTONIO ONG</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/12/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Bethel Hebrew</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Varley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sylvan Lewis & Son Garrison, Md</u>	
24D. LOCATION <u>Reisterstown</u>		24E. LOCATION (City, town, or county) (State) <u>Md</u>		24F. ADDRESS <u>Baltimore</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-455 71 3596		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3596	
1. NAME OF DECEASED (Type or Print) HUGO ULLMAN		2. DATE AND HOUR OF DEATH March 30, 1971 11:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore B. COUNTY Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 42 2505 W. Belvedere Ave #15					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/25/85	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-26-7695		17. INFORMANT Hoop chair	
18. 600X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) UNKNOWN		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3-29-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-21 19 71 to 3-30 19 71 that (I) (we) last saw the deceased alive on 3-30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. San Gabriel MD				23B. DATE SIGNED 3-30-71	
23C. PHYSICIAN'S NAME (Type) I. SAN GABRIEL MD		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/1/71		24C. NAME of CEMETERY or CREMATORY Hebrew Friendship	
24D. LOCATION Balto		24E. (City, town, or county) (State) Md			
25A. DATE REC'D BY HEALTH DEPT. APR 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.		25C. FUNERAL DIRECTOR Sylvan Lewis & Son 9610 Reisterstown Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3597</u>	
BIRTH NO. <u>M-420</u>		71 3597		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>James S. Malecki</u>			2. DATE AND HOUR OF DEATH <u>4-5-71</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>			A. STATE <u>Md.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2029 Fleet St.</u>			B. COUNTY <u>203</u>		
5. SEX <u>M</u>			6. RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3-4-16</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Mech. Port Authority</u>			9. AGE (In years last birthday) <u>55</u>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Peter</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Giersz</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs. Rose Witt</u>		
18. <u>4/2/71</u>			ADDRESS <u>929 Belvidere Ave</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>Angina Pectoris</u>		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF: <u>1970</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Coronary Atherosclerosis</u>		
			DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>		
			(C) <u>Arteriosclerotic, Hypertensive Cardio-</u>		
			<u>?</u>		
II			Vascular Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>None</u>				<u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 8</u> 19 <u>70</u> to <u>April 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph F. Drenga</u>				23B. DATE SIGNED <u>4/6/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph F. Drenga, M.D.</u>				23D. ADDRESS <u>209 S. Chester St.; Baltimore, Md. 21231</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-9-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>	
24D. LOCATION <u>Balto. Md</u>		24E. FUNERAL DIRECTOR <u>Raymond L. Kaczorowski</u>		24F. ADDRESS	
25A. DATE RECORDED BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME OF REGISTRAR <u>James E. [illegible]</u>		25C. FUNERAL DIRECTOR <u>Raymond L. Kaczorowski</u>	

Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

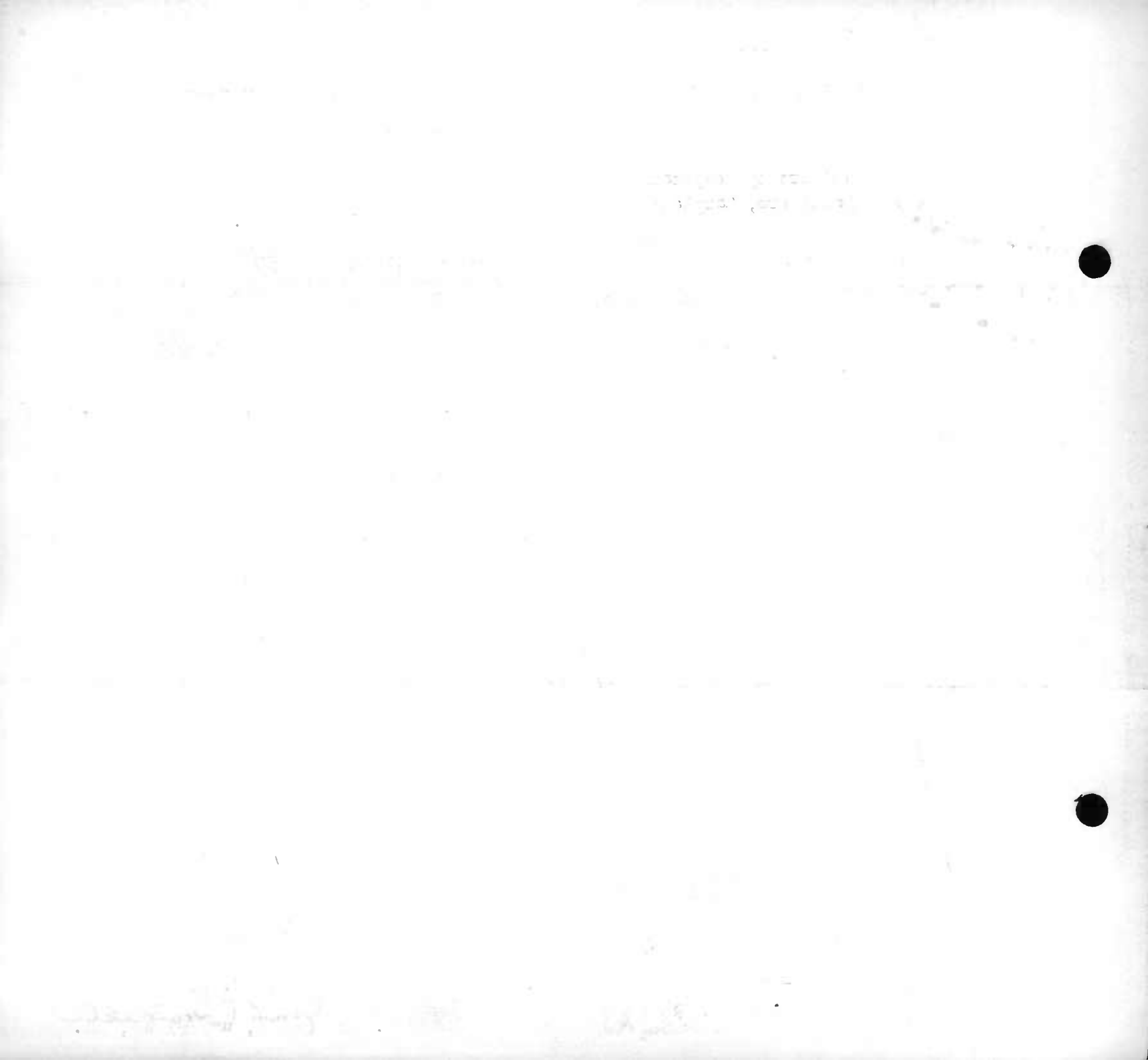
Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

operation date - please recheck - about 8 weeks ago

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-256		71 3598		BALTIMORE CITY HEALTH DEPARTMENT		71 3598	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Walter Whisner</u>				2. DATE AND HOUR OF DEATH <u>4/11/71 - 4-11-71</u> <u>7:29 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Allegany</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38</u> <u>University Hospital</u> <u>Baltimore, Maryland</u>				C. CITY OR TOWN <u>Cumberland</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1019 Lexington Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1912</u>	9. AGE (in years last birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tire Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John S. Whisner</u>				14. MOTHER'S MAIDEN NAME <u>Cora May Gordon</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Flossie Whisner, Cumberland Md. - Wife</u>			
18. <u>3-90-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>gastritis with massive hemorrhage 8 weeks</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>acute and chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>chronic pyelonephritis</u> years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>8 weeks</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>bleeding gastritis</u>		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>4 April 1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6 April 1971</u> to <u>4 April 1971</u> that (I) (we) lost saw the deceased alive on <u>4 April 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>David W. Fricke MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>David W Fricke</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-14-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Restlawn Mem. Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>La Vale, Md. Allegany County</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>			



1

W-340 71 3599 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3599

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD WOTHLIE

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ March 17, 1971 5:46 P.M.

3. DATE PRONOUNCED DEAD Month Day Year Hour
March 17, 1971 5:46 P.M.

4. PLACE OF DEATH (If in hospital or institution, give street address or location) 7-15-71
Sinai Hospital

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 2841

6. SEX Male 7. RACE White 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 10. AGE (In years lost birthday) 58 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4511 Groveland Avenue

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 3-17-71 ? 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Apparently shot self

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED March 18, 1971

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 4-13-71 24C. NAME OF CEMETERY 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. APR 13 1971 25B. NAME OF REGISTRAR Robert E. Farber, M.D. 25C. FUNERAL DIRECTOR ADDRESS

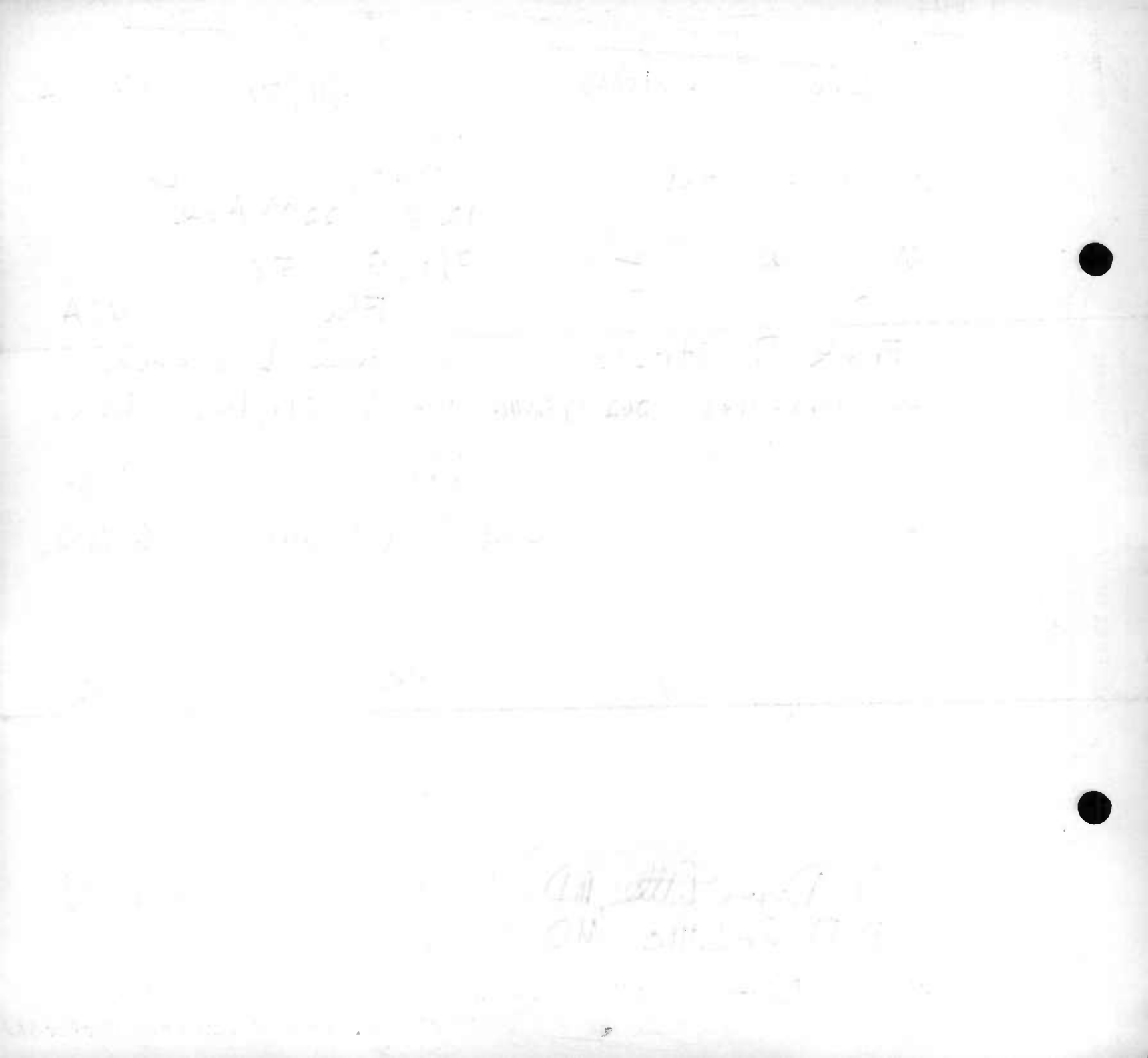
ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCMD

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

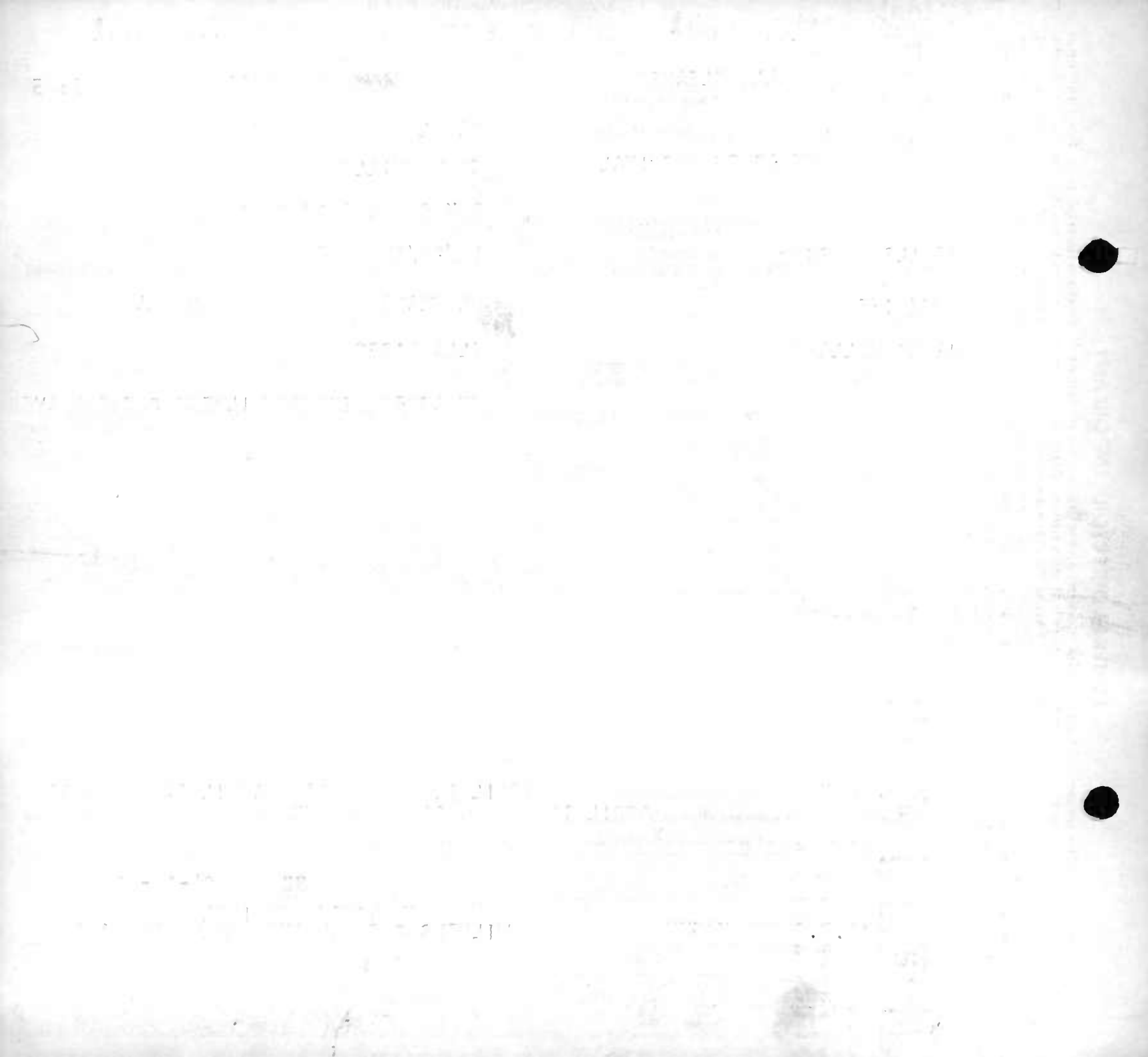
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
71 3600					71 3600					
BIRTH NO. <u>S-362</u>					REG. NO. <u>71 3600</u>					
1. NAME OF DECEASED (Type or Print) <u>Lawrence S. Struss</u>					2. DATE AND HOUR OF DEATH <u>4/11/71</u> <u>1845</u> <u>A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>US PHS Hospital</u> <u>2X</u>					A. STATE <u>Fla</u> B. COUNTY <u>V-08</u>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Tampa</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER <u>1203</u> <u>22nd Ave</u>										
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/4/13</u>		9. AGE (In years last birthday) <u>58</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Fla</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Frank R. Struss</u>					14. MOTHER'S MAIDEN NAME <u>Corinne Lawrence</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1942 - 1946</u>					16. SOCIAL SECURITY NO. <u>262 09 5646</u>		17. INFORMANT <u>Mrs. J.W. Clayton</u>			
18. <u>15-0X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>		
					(B) <u>Ca of Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF			<u>6 mos.</u>		
					(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>R. Roger Little MD</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>4/11/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>R. Roger Little MD</u>					23D. ADDRESS <u>Wynn Park Drive</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4-15-1971</u>			24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Tampa Fla.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Charles F. Evans & Son 8802 Harford Rd.</u>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. Such

VS 150-REV. 1/1/68



1. NAME OF DECEASED (Type or Print) Annie R. Herman (Harmon)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 11 71 5:50p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1012 N. Carey St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 11 71 5:50 p.M.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-30-43		10. AGE (In years last birthday) 27 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Booker Harrison		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1602	
15. MOTHER'S MAIDEN NAME Rose Thompson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 219-40-3184		18. INFORMANT Margaret Thompson	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 304.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 4/12/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-15-71	
24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kelson F. H.		ADDRESS 1348 Calhoun St.	

Letter from M.E.'s office

5-7-71

M.H.

VALLEY FOUNDRY

207-0000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3603	
<p><i>W-452</i> 71 3603</p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Gladys M. Williams</i></p>		<p>2. DATE AND HOUR OF DEATH <i>Apr - 11 - 1971 11 10 PM M.</i></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran hospital of Maryland</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Maryland</i> B. COUNTY <i>1607</i></p> <p>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>3118 Bapker street</i></p>			
<p>5. SEX <i>F</i></p>	<p>6. RACE <i>C</i></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>11/5/10</i></p>	<p>9. AGE (In years last birthday) <i>60</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <i>Md.</i></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>		<p>13. FATHER'S NAME <i>Elmer Sampson</i></p>			
<p>14. MOTHER'S MAIDEN NAME <i>unknown Ida Newman</i></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>			
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <i>Kate Sampson - same</i></p>			
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p><i>153.81</i></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <i>Cachexia due to</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <i>distant metastasis of colon Ca 11 months</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>					
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <i>2</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <i>Yes.</i></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>March 15 1971</i> to <i>Apr - 11 1971</i> that (I) (we) lost <i>we</i> saw the deceased alive on <i>Apr - 11 1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>Myung Duck Ro</i></p>				<p>23B. DATE SIGNED <i>Apr - 11 - 71</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>Myung Duck Ro</i></p>				<p>23D. ADDRESS <i>Lutheran hospital Balt. Ad. 21216</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>4-16-71</i></p>		<p>24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary Cen.</i></p>	
<p>24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1971</i></p>			
<p>25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i></p>		<p>25C. FUNERAL DIRECTOR <i>Kelso A.H. 1348 Calhoun St.</i></p>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3604

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WARNIE BLACK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1223 E. Biddle St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 9 1971 3:31 p.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1001	
9. DATE OF BIRTH 1-23-28		10. AGE (in years lost birthday) 43 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Blank		14. STREET AND NUMBER 1223 E. Biddle St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Carrie L. Brown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO.	
18. INFORMANT Rev. Wm H. Black		ADDRESS 2512 Edgcomb Circle	
19. CAUSE OF DEATH 011, 2, 4303.2 Active cavity tuberculosis DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. DATE SIGNED 4/10/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/71	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

1-23-88

North Carolina

William B. Black

Charles L. Brown

Yes Will

Rev. W. B. Black 2012

James L. Brown

General

General

James L. Brown

James L. Brown

James L. Brown

A-450		71 3605		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 3605		
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) P. James Allen					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 4 Day 11 Year 71 Hour 10:15 a. Estimated <input type="checkbox"/>					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital					3. DATE PRONOUNCED DEAD Month 4 Day 11 Year 71 Hour 10:15 a.					
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 806										
6. SEX male		7. RACE Negro		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH 10-19-47		10. AGE (In years last birthday) 23		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1704 Durham St.				
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Julius J. Allen				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Lucille Harris				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Shirley D. Allen 1035 Orlean St.				
19. E 9661 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH Stabwound of left axilla (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION 2					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) APARTMENT					22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1201 N. Caroline St.-3rd floor apt. 808
22D. TIME OF INJURY (APPROX.) Month 4 Day 11 Year 71 Hour 2:30a					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					22F. HOW DID INJURY OCCUR? Subject found stabbed
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 4/12/71										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-16-71		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery			24D. LOCATION (City, town, or county) (State) Balto., Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971				25B. NAME OF REGISTRAR Wm C March			25C. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.			

• • •

15-25-4

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
J. WILLIAM REHAL		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Apr. 10, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		Month Day Year Hour 4- 10 1971 2:45 p.m.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
male	7. RACE white	A. STATE Md. B. COUNTY 702	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		E. STREET AND NUMBER	
July 28, 1903.		816 N. Kenwood Ave.	
10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
67		Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		William J. Reichliel	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Maintenance		Katherine Blum	
14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Self Employed		No	
17. SOCIAL SECURITY NO.		18. INFORMANT	
		Mrs. Mary Kinlein	
19. CAUSE OF DEATH		ADDRESS	
412.7		3749 Elmore Ave.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic cardiovascular disease			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No)	
2		yes	
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:			
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Isidore Mihalakis, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED			
4/11/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		4/14/71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Holy Redeemer		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
APR 14 1971			
25C. FUNERAL DIRECTOR		ADDRESS	
Leonard J. Ruck, Inc.		Balto. Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3607

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STANLEY Kalbarczyk		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 10 1971 7:08 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2734	
9. DATE OF BIRTH 12/8/1919		10. AGE (In years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Kalbarczyk		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic	
15. MOTHER'S MAIDEN NAME Josephine unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 166 14 7175		18. INFORMANT Mrs. Victoria Kalbarczyk	
19. 4124 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 4/10/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/71	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS Inc. Balto. Md.	

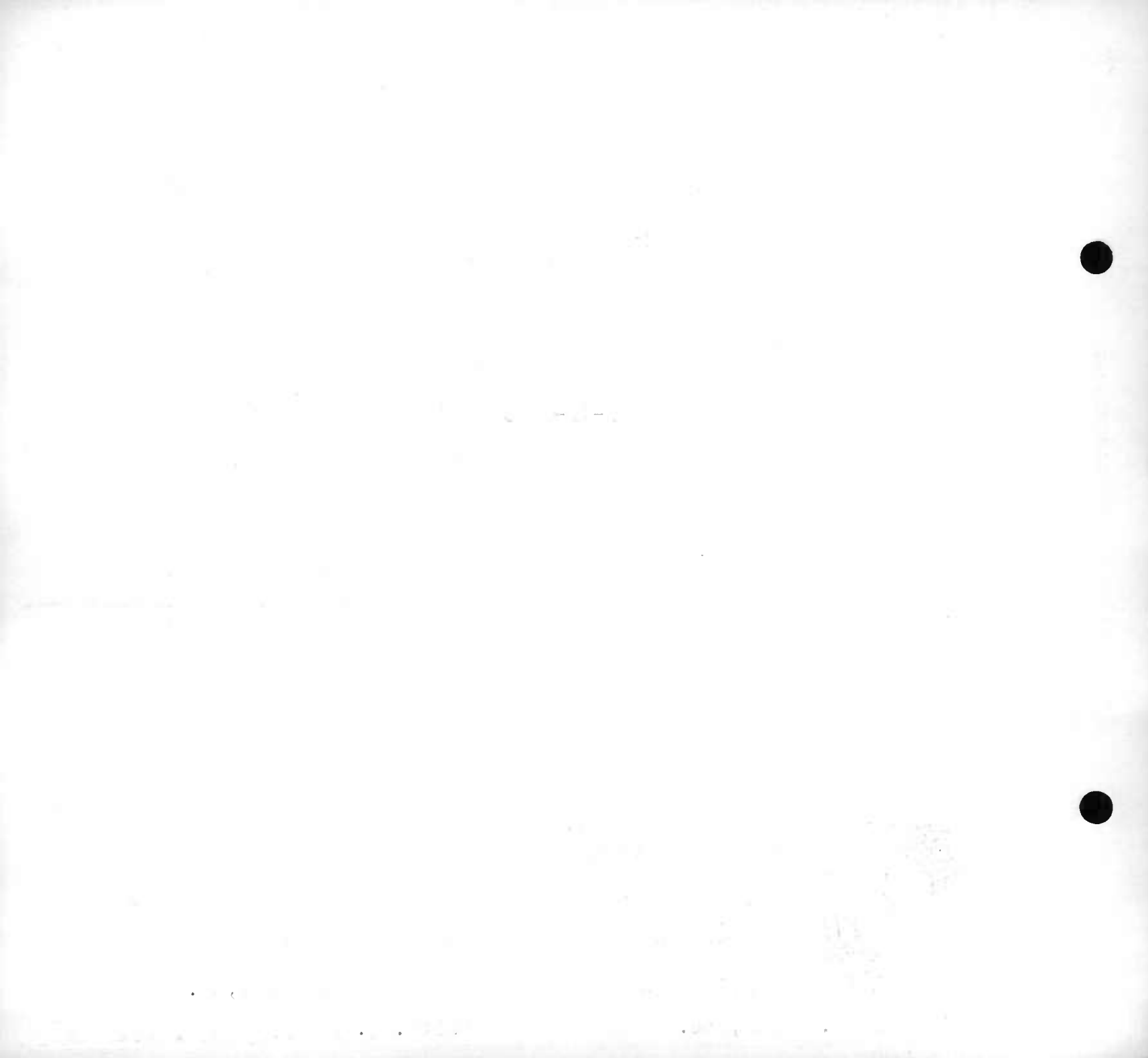
Xy

WALLEY FOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3608	
BIRTH NO. P-362 71 3608		CERTIFICATE OF DEATH			
1. NAME OF DECEASED <small>(Type or Print)</small> PETERS, LORETTA M.		2. DATE AND HOUR OF DEATH 4/10/71 4:03 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2733 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2911 STRATMORE AVE.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-31-05	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Miller, Leo		14. MOTHER'S MAIDEN NAME Steinmeir, Josephine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 213-03-1265		17. INFORMANT ADDRESS Clifford Peters	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ACUTE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/9/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/9 19 71 to 4/10 19 71 that (I) (we) last saw the deceased alive on 4/10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Earl Cotman, M.D.				23B. DATE SIGNED 4/10/71	
23C. PHYSICIAN'S NAME (Type) H. Earl Cotman, M.D.				23D. ADDRESS Union Memorial Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Balto. Md. LEONARD S. RUCK INC. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
1-300		71	3609	71 3609	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) </div> <div> CERTIFICATE OF DEATH </div> </div>					
HELEN E LLOYD			2. DATE AND HOUR OF DEATH April 11, 1971.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines (Belair Rd.)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 2745 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6509 Moyer Ave		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1894	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Lady		10B. KIND OF BUSINESS OR INDUSTRY Reese Press		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Whitcomb			14. MOTHER'S MAIDEN NAME Amanda Cullum		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-4057		17. INFORMANT Mrs Doris Minderlein	
				ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia (B) Antecedent Cause DUE TO, OR AS A CONSEQUENCE OF: Colon (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/21/71 to 4/11/71 that (I) (we) last saw the deceased alive on 4/11/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley MD				23B. DATE SIGNED 4/12/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 4900 Belair Road, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/14/71		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 14 1971		Robert E. Talley, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 3610	
B-200 71 3610		BIRTH NO.		2. DATE AND HOUR OF DEATH 4.12.1971 1.30 A.M.	
1. NAME OF DECEASED (Type or Print) REGINA, C. BOGY		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital 35 Baltimore MD. 21231			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore		5. CITY OR TOWN 8525 Oak Rd.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 8525 Oak Road (34)		5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 10.03-93		9. AGE (In years lost birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Oliver Ford		14. MOTHER'S MAIDEN NAME Mary Hagedorn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-4236		17. INFORMANT William V Bogy ADDRESS (668607)	
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 20A. AUTOPSY? (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 0		(A) IMMEDIATE CAUSE ASHD DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction & complete A-V block (B) DUE TO, OR AS A CONSEQUENCE OF: 0 (C) DUE TO, OR AS A CONSEQUENCE OF: 0			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from 4.9 19 71 to 4.12 19 71 that (I) was last saw the deceased alive on 4.12 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) did not view the body after death.					
23A. SIGNATURE Abdus Samad MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4.12.1971	
23C. PHYSICIAN'S NAME (Type) ABDUS SAMAD MD		23D. ADDRESS Church Home & Hospital Baltimore MD 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/71		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 14 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Buck Inc. 5305 Harford Rd.			

1914-15-16

1914-15-16

1914

1914

1914

1914

1914-15-16

1914-15-16

1914-15-16

1914

1914

1914-15-16

1914

1914

1914

1914-15-16

1914-15-16

1914-15-16

1914

1914

1914

1914

1914

1914

1914-15-16

1914

1914

1914-15-16

1914-15-16

1914

1914-15-16

1914-15-16

1914-15-16

1914-15-16

B-26071

3611

BALTIMORE CITY HEALTH DEPARTMENT

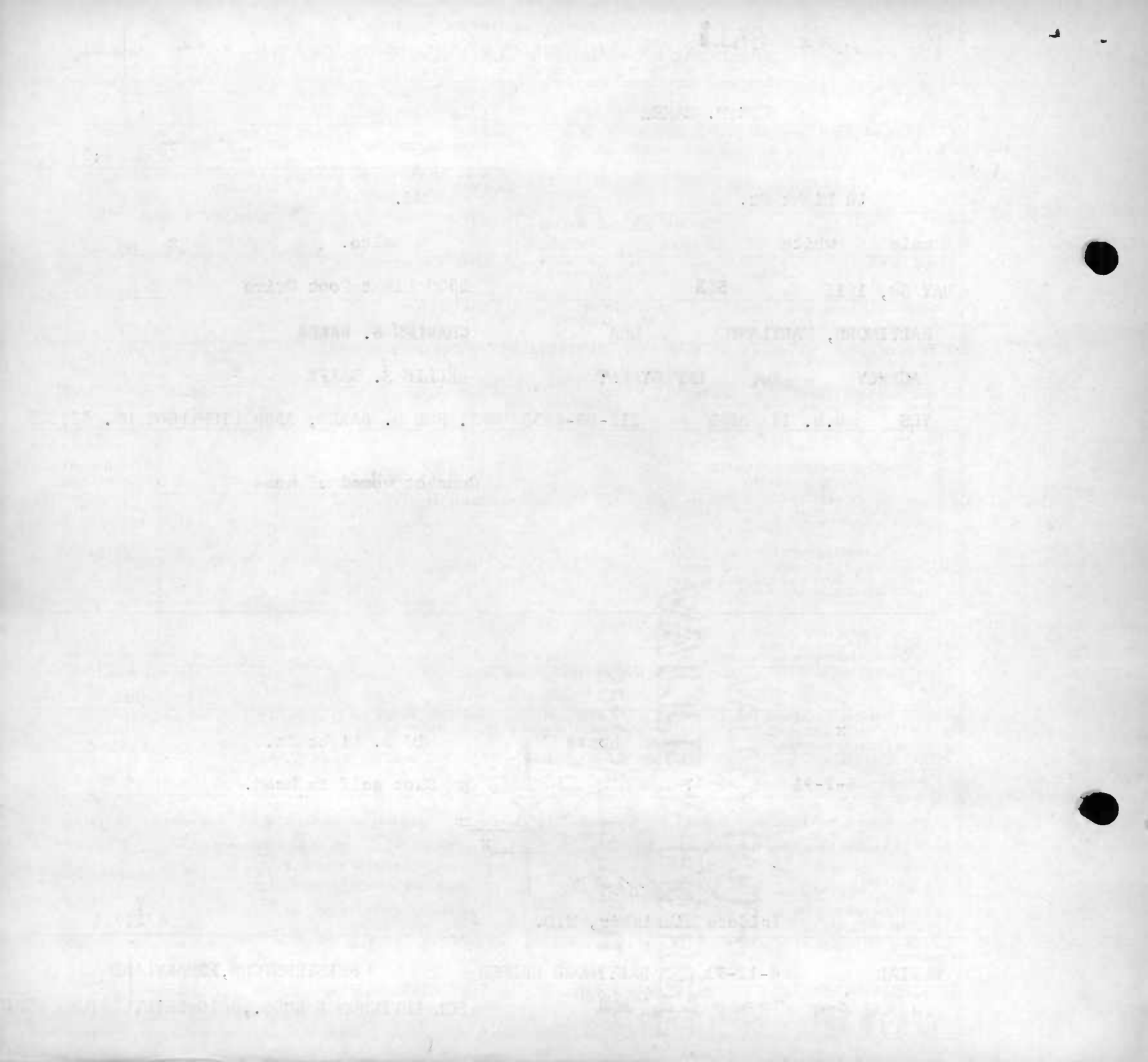
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3611

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEE N. BAKER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 10 Light St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 10 1971 6:34 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5300	
9. DATE OF BIRTH MAY 30, 1915		10. AGE (In years lost birthday) 55 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENCY		14B. KIND OF BUSINESS OR INDUSTRY EMPLOYMENT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		17. SOCIAL SECURITY NO. 215-03-6933	
18. INFORMANT MRS. SUE G. BAKER		ADDRESS 3309 LIGHTFOOT DR. #21208	
19. CAUSE OF DEATH E955X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2-7-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 10 S. Light St. 401		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 4-?-71 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self in head.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/11/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-12-71	
24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3612		71 3612	
W-550				X		REG. NO.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Weinman, Paul</u>		2. DATE AND HOUR OF DEATH MARTIN <u>04-08-71</u> <u>6:24 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		5. CITY OR TOWN <u>PIRESVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>				E. STREET AND NUMBER <u>3500 WOODVALLEY DR.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-51</u>	9. AGE (in years last birthday) <u>19</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MELVIN WEINMAN</u>				14. MOTHER'S MAIDEN NAME <u>TOBY GOLDMAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. MELVIN WEINMAN, 3500 WOODVALLEY DR. #21208</u>	
18. <u>186X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Liver failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>malig. testicular tumor</u> <u>metastasis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>6:24 PM 8th April 71</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>20 Mar</u> 19 <u>71</u> to <u>8 Apr</u> 19 <u>71</u> that (I) <u>lost</u> saw the deceased alive on <u>8 Apr</u> 19 <u>71</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>did</u> <u>not</u> view the body after death.							
23A. SIGNATURE <u>J. H. H.</u>				23B. DATE SIGNED <u>8 April 71</u>		23C. PHYSICIAN'S NAME (Type) <u>SEIDO JITSUKAWA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-9-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH EL MEMORIAL PARK</u>		24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			

MS A.12

MS A.12

THE UNIVERSITY OF CHICAGO

LIBRARY

1944

1944

1944

44

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3613

BIRTH NO. J-212 71 3613

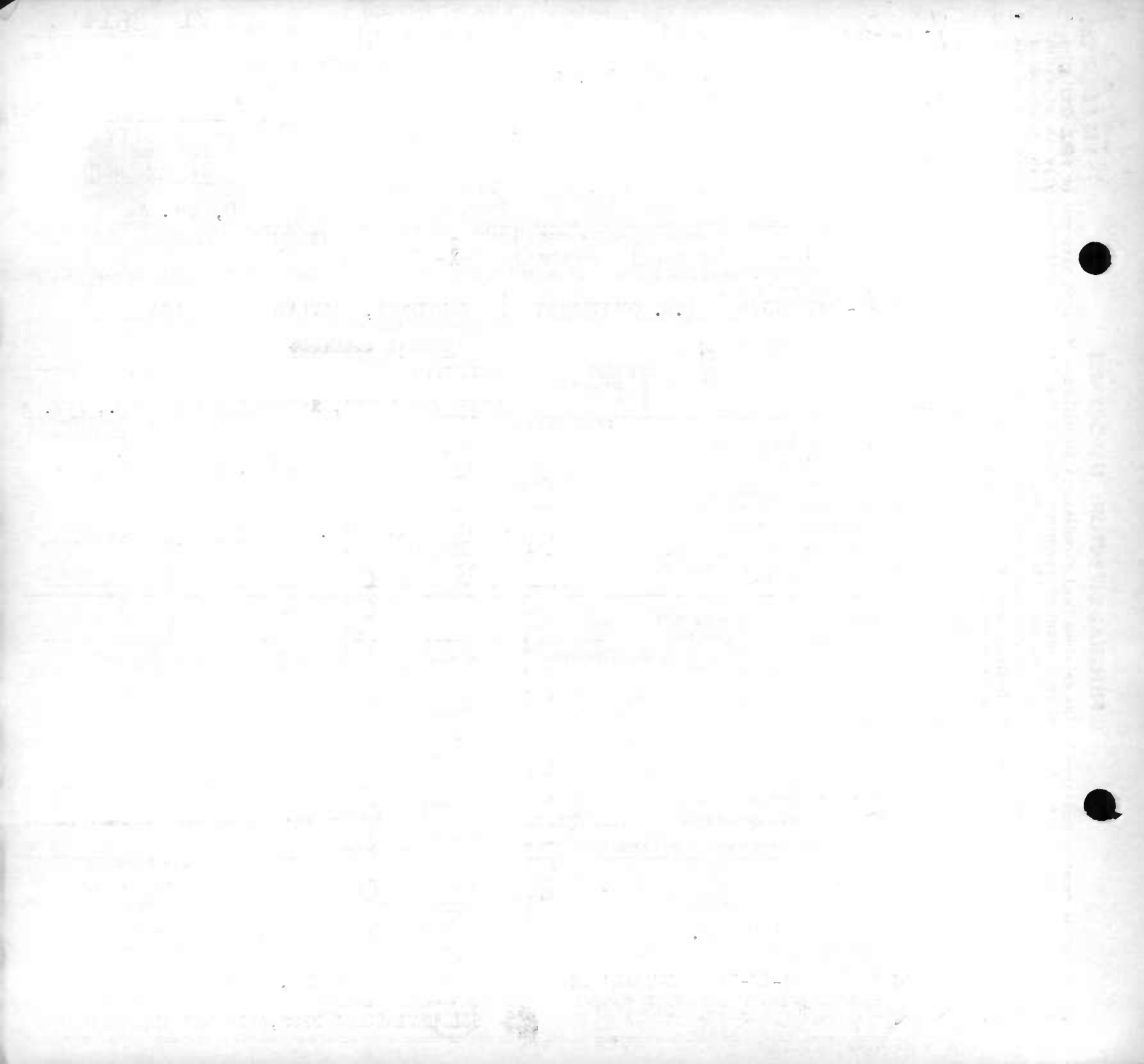
1. NAME OF DECEASED (Type or Print) LEONARD D. JACOBS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 10 1971 8:28 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Howard C. CITY OR TOWN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER TAYLOR MANOR NURSING HOME	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH MAY 11, 1918		10. AGE (In years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		14B. KIND OF BUSINESS OR INDUSTRY SECURITY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		17. SOCIAL SECURITY NO. 218-10-2526	
18. INFORMANT MR. SAMUEL SMALKIN, TITLE BLDG. 6th FL. #2		15. MOTHER'S MAIDEN NAME RAY MYERS	
19. CAUSE OF DEATH E965 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of back of chest and abdomen DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTecedent CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME OF INJURY (APPROX.) 4-10-71 8:15 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1820 N. Charles St.		22F. HOW DID INJURY OCCUR? Shot by unknown assailant.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/11/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-12-71	
24C. NAME OF CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital (and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. <u>71 3614</u>		CERTIFICATE OF DEATH		REG. NO. <u>71 3614</u>	
1. NAME OF DECEASED (Type or Print) <u>Jesse Yaffa</u>				2. DATE AND HOUR OF DEATH <u>4/10/71</u> <u>1 8:00</u> P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hosp</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3809 FORDLEIGH ROAD, Apt. A</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-02</u>		9. AGE (In years last birthday) <u>69</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-TECHNICIAN</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY YAFFA</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE BENDER</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MISS DORA YAFFA, 3809 FORDLEIGH RD., APT. A</u>				ADDRESS	
18. <u>4/10/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u> <u>? Myocardial infarct</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Hemophilia</u> <u>life</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) <u>Depression</u> <u>20 yrs</u>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR							
22. I certify that (1) (this hospital) attended the deceased from <u>4/10</u> 19 <u>71</u> to <u>4/10</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Kevin J. Hunt (MD)</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/10/71</u>					
23C. PHYSICIAN'S NAME (Type) <u>KEVIN J. HUNT</u> DEGREE				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-12-71</u>		24C. NAME of CEMETERY or CREMATORY <u>SHAAREI ZION</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>Valerie E. Miller</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u>		ADDRESS <u>6010 REISTERSTOWN ROAD</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-462 71 3615		BALTIMORE CITY HEALTH DEPARTMENT		71 3615	
BIRTH NO.		CERTIFICATE OF DEATH		X REG. NO.	
1. NAME OF DECEASED (Type or Print) CHESTER J. FLOWERS		2. DATE AND HOUR OF DEATH 4-11-71 9:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Maryland B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel Co		8. DATE OF BIRTH 8-17-11	
13. FATHER'S NAME Vincent Flowers		14. MOTHER'S MAIDEN NAME ?		9. AGE (In years last birthday) 59	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 214-03-2546		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT BCH Records: Baltimore, Md. 21224		12. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ventricular fibrillation		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction - 4 weeks		(B) Arteriosclerotic Cardiovasc. Disease - years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Staphylococcal pneumonia		(C) _____			
19A. DATE OF OPERATION 4-11-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-8 19 71 to 4-11 19 71 that (I) (we) last saw the deceased alive on 4-11 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. DeWayne Andrews M.D.		23B. DATE SIGNED 4-11-71		23C. PHYSICIAN'S NAME (Type) M. DeWayne Andrews	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-71		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.R.		25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE	
24D. LOCATION BALTIMORE MARYLAND		24E. ADDRESS 4940 Eastern Ave., Balto. Md. 21224			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

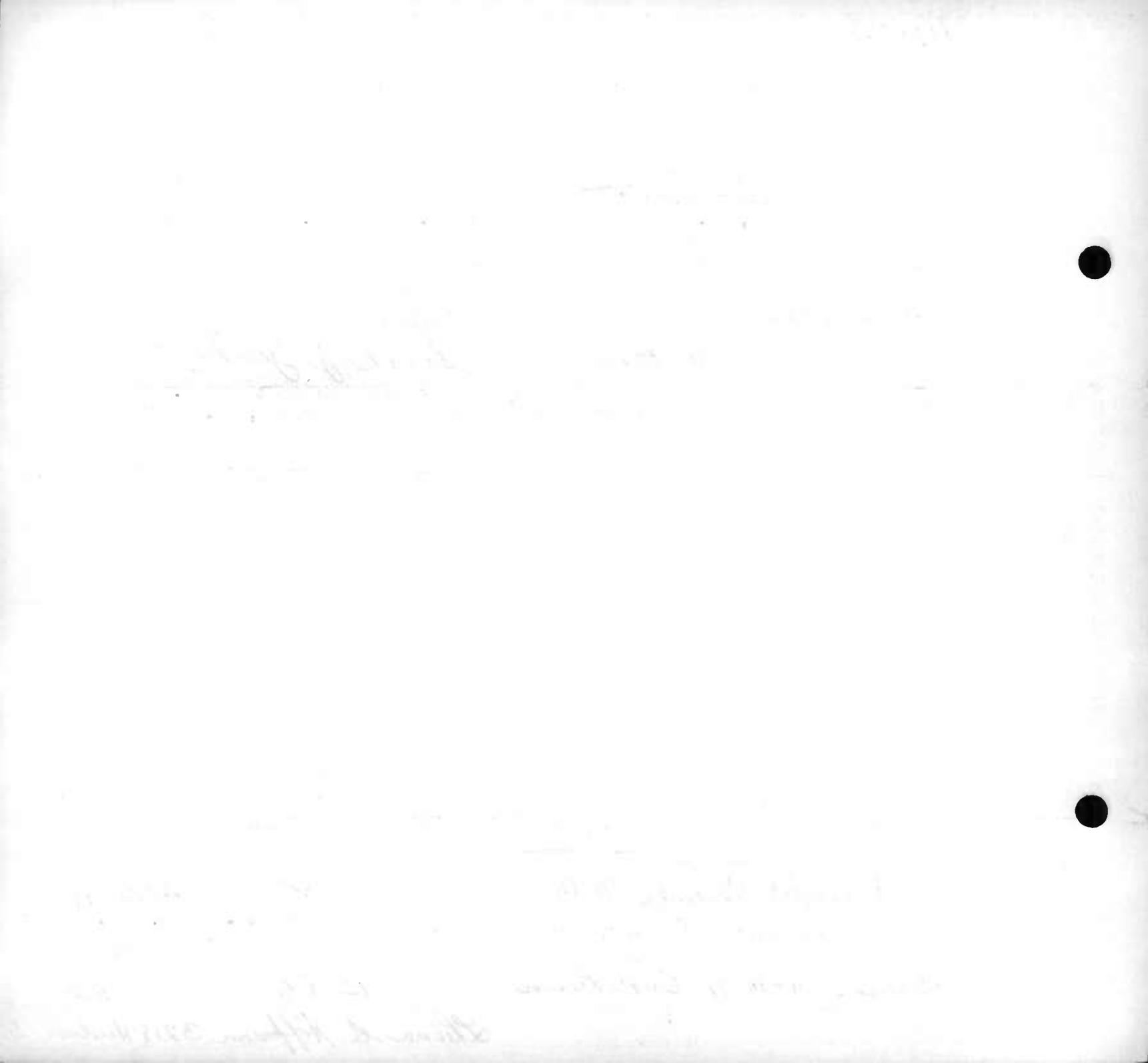
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3616	
H-431 71 3616 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LOUISA HILDEBRECHT		8 Apr 1971 300 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			A. STATE Md.		
			B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2219 Jefferson St.		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-98	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Christopher Hildebrecht		
14. MOTHER'S MAIDEN NAME Catherine Volz			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		
16. SOCIAL SECURITY NO.			17. INFORMANT Harry W. Ferkler, 3340 E. Balto. St. 21224		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Broncho-pneumonia	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure - U.T.I.	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 16 1971 to Sept 7 1971 that (I) (we) last saw the deceased alive on Sept 7 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Helfrich				23B. DATE SIGNED 9 Apr 71	
23C. PHYSICIAN'S NAME (Type) William Helfrich MD				23D. ADDRESS 5006 Roland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		12 April 71		Zion Lutheran Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR Ullrich Funeral Homes, Balto., Md. 21206	
25D. LOCATION (City, town, or county)		25E. ADDRESS			
Baltimore Co., Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

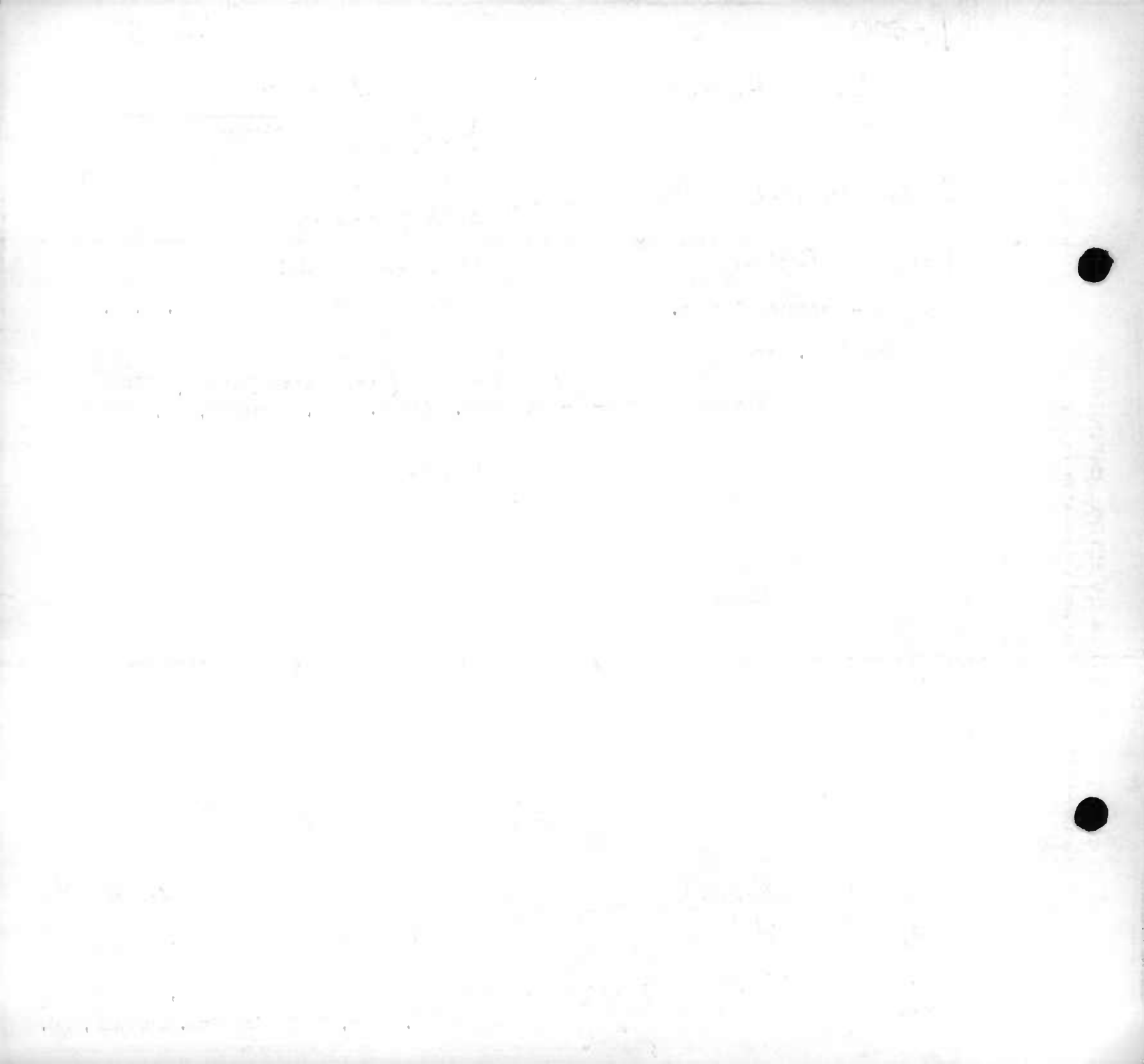
BIRTH NO. <u>M-241 71 3617</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3617</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
<u>Sarah J. Mausolf</u>				<u>4/12/71</u> <u>6:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2609</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1015 S. Baylis St. 21224 007</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-96</u>	9. AGE (in years last birthday) <u>74</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>				13. FATHER'S NAME <u>John Watson</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah J. Jenkins</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>213-05-8799</u>				17. INFORMANT <u>BCH-Records Baltimore, Md. 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Breast Ca</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Breast Ca</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>4-12-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>April 12 1971</u> to <u>April 12 1971</u> that (I) (<u>we</u>) last saw the deceased alive on <u>April 12 1971</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dwight Cramer M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/12/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dwight Cramer M.D.</u>				23D. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-16-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>Shelma A. Hoffman</u>		25C. FUNERAL DIRECTOR <u>3218 Hudson St.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. 71 3618				
<div style="display: flex; justify-content: space-between;"> L-500 71 3618 </div>									
1. NAME OF DECEASED (Type or Print) LANE, RUDOLPH					2. DATE AND HOUR OF DEATH 4-11-71 7:25 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC.					A. STATE MARYLAND B. COUNTY Baltimore				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Dundalk			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
					E. STREET AND NUMBER 3135 YORKWAY				
5. SEX MALE		6. RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-26		9. AGE (In years last birthday) 44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager - Eastern Tire Co.					11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jessie E. Lane					14. MOTHER'S MAIDEN NAME Emma Goff				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII & Korean					16. SOCIAL SECURITY NO. 220-18-2750		17. INFORMANT (Wife) 3135 Yorkway, ADDRESS Mrs. Nila J. Lane, Dundalk, Md. 21222		
18. 162 / I CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last									
(A) IMMEDIATE CAUSE TERMINAL C.A. OF LUNG DUE TO, OR AS A CONSEQUENCE OF:									
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:									
(C) _____									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION AUGUST 1970			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GOOD			20A. AUTOPSY? (Yes or No) VP.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from 4-9-71 to 4-11-71 that (2) (we) last saw the deceased alive on 4-11-71 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Sahachai Musikabhumta</i>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4-11-71	
23C. PHYSICIAN'S NAME (Type) SAHASCHAI MUSIKABHUMTA					23D. ADDRESS SINAI HOSPITAL OF BALTIMORE INC.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/14/71		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971			25B. NAME OF REGISTRAR <i>Robert E. J. ...</i>			25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

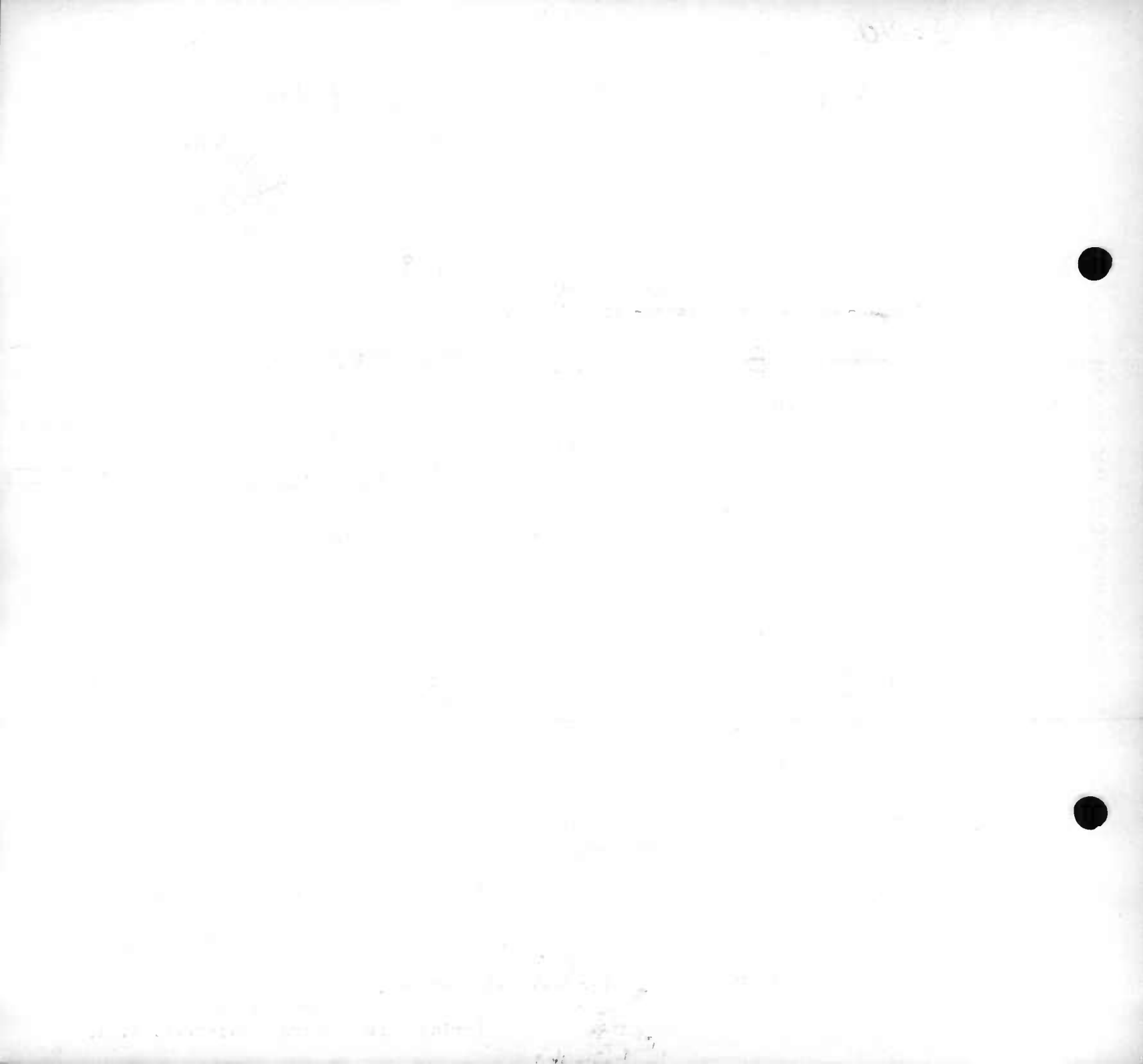
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 3619	
P-620		71 3619		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PARKS, Marjorie A.		4x2x 4/12/71 8:10 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		V-08	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Florida		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
33 The Johns Hopkins Hospital		Pensacola		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
9/19/05		65		Home Maker	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY	
		U.S.A.		OWN HOME	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
John Atlee		Marjorie		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		WATERS + H. D. BERT F. H.		PENSACOLA, FLA.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		25 min	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Cardiac arrest			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 wks	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Laryngeal edema			
		(C) Radical neck for squamous cell CA		4 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
3/11/71		Radical neck squamous cell CA		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
NO				(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from March 16 19 71 to April 12 19 71 that (1) (we) last saw the deceased alive on April 12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Philip Rosenbloom MD		4/12/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Philip Rosenbloom, M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATOR	
BURIAL		4-15-71		St. John's Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 14 1971		Robert E. Taylor, M.D.		Wm. Cook-Brooks-Towson, Inc.	
				ADDRESS 1050 YORK RD TOWSON, Md.	

FUNERAL DIRECTOR: IMPORTANT

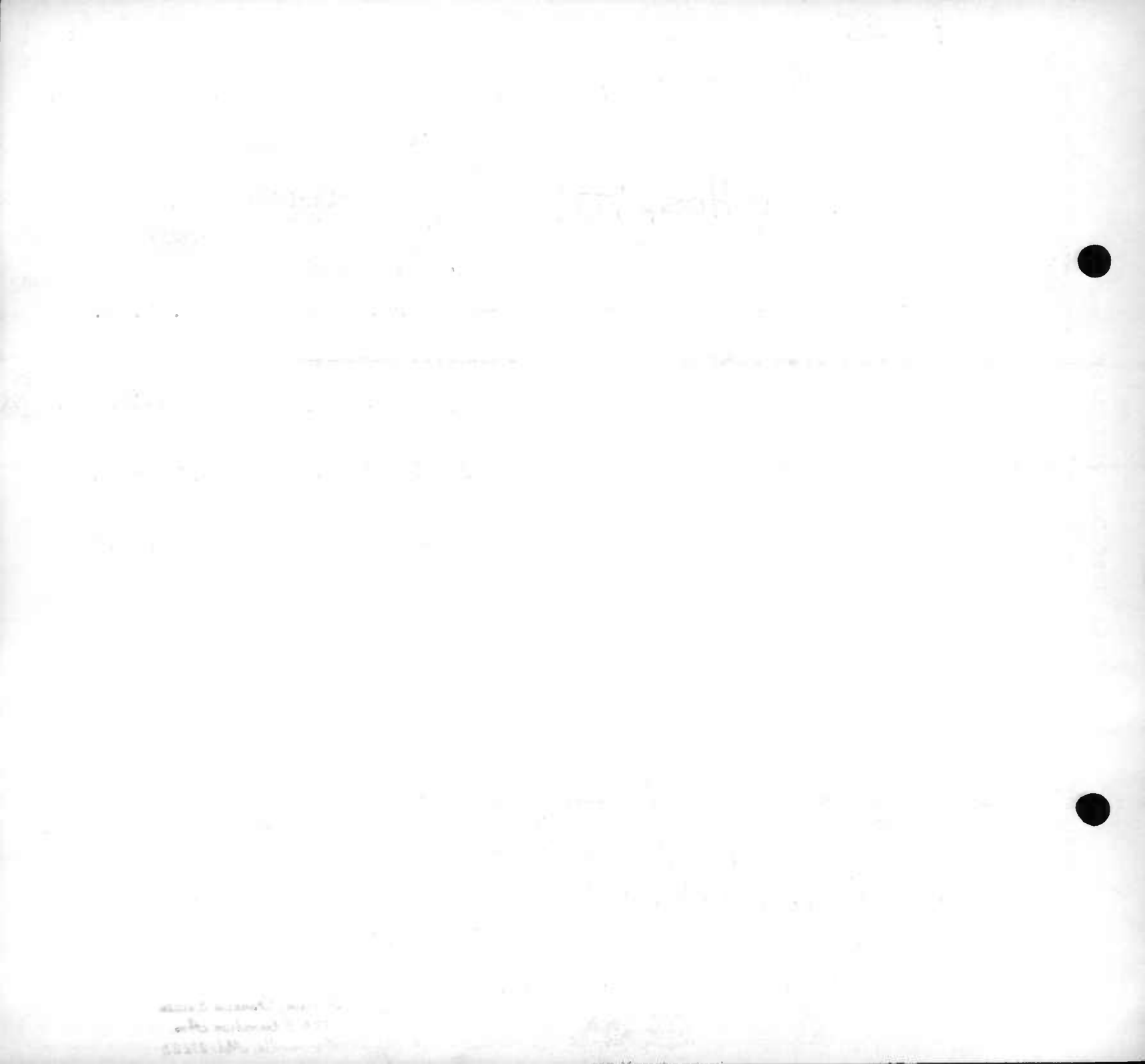
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 3620	
A-654 71 3620				BIRTH NO.			
1. NAME OF DECEASED Opal Espy Arnold (Cockerham)				2. DATE AND HOUR OF DEATH 4/10/71 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital				A. STATE Md.		B. COUNTY Baltimore Co. (2)	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Randallstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 9216 Liberty Rd.		21133	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/07	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sales Lady				10B. KIND OF BUSINESS OR INDUSTRY McDonalds Clothing Store - Randallstown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pinkney B. Cockerham				14. MOTHER'S MAIDEN NAME Amanda Davis			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. 242-05-6190		17. INFORMANT Charles M. Arnold	
18. 34801 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PULMONARY ATLECTASIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/31 - 4/10/71			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure			
ANTECEDENT CAUSES				(B) Amphotrophic Lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF: 1969			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None							
19A. DATE OF OPERATION 3/4/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy for Resp.		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/31/71 19 to 4/10/71 19 that (1) (we) last saw the deceased alive on 4/9/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bayani B. Elma, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/10/71	
23C. PHYSICIAN'S NAME (Type) BAYANI B. ELMA M.D.				23D. ADDRESS MD. GEN HOSP 927 WILKIN AVE BALTO MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/1971		24C. NAME of CEMETERY or CREMATORY Lake View Memorial Park Cem.		24D. LOCATION (City, town, or county) (State) Sykesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR 8728 Liberty Road Loring Byers Funeral Directors, P. A.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-235		71 3621		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 71 3621	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert J. Ashton				2. DATE AND HOUR OF DEATH 4-12-71 12:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital						A. STATE Maryland		B. COUNTY Baltimore	
						C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6011 Hunt Ridge Road									
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1904		9. AGE (In years last birthday) 67		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-Horseowner & Consultant-Racing				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John William Ashton				14. MOTHER'S MAIDEN NAME Lucelle Johnson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-09-0704		17. INFORMANT Mrs. Mildred H. Ashton-6011 Hunt Ridge			
				ADDRESS 2-21210 Rd					
18. 4-10-71 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarct.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
						(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: Years			
19A. DATE OF OPERATION 0						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that my (this hospital) attended the deceased from 4-8-71 19 to 4-12-71 19 that (I) was lost saw the deceased alive on 4-12-71 19 and that (in my) own opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death.									
23A. SIGNATURE Benedict A. Termini						23B. DATE SIGNED 4-12-71			
23C. PHYSICIAN'S NAME (Type) BENEDICT A. TERMINI						23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sterling Funeral Estate ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
CERTIFICATE OF DEATH				REG. NO. <u>71 3622</u>	
BIRTH NO. <u>W-300</u>		71 3622			
1. NAME OF DECEASED (Type or Print) <u>WOOD, ALMA LUCILLE</u>			2. DATE AND HOUR OF DEATH <u>APRIL 11 1971</u> <u>3:00P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUE</u> <u>BALTIMORE MARYLAND 21229</u>			C. CITY OR TOWN <u>CATONSVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>23 BISHOPS LANE 21228</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06 11 56</u>	9. AGE (In years last birthday) <u>14</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>JAMES W. WOOD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>NANCY MARTINDALE</u>
			17. INFORMANT <u>RECORDS</u>		ADDRESS <u>ST AGNES HOSPITAL CATON & WILKENS AVE</u>
18. <u>486X17070X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bilateral Pneumonia and Fulminating Hepatitis.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bilateral Pneumonia and Fulminating Hepatitis.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>MARCH 13 1971</u> to <u>APRIL 11 1971</u> that <u>(X)</u> (we) last saw the deceased alive on <u>APRIL 11 1971</u> and that in <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>04 11 71</u>		
23C. PHYSICIAN'S NAME (Type) <u>SALVADOR QUIROZ M.D.</u>			23D. ADDRESS <u>CATON & WILKENS AVENUE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/14/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cem</u>	
24D. LOCATION <u>Ellicott City, Howard, Md</u>		24E. NAME OF REGISTRAR <u>[Signature]</u>		24F. FUNERAL DIRECTOR <u>E. S. MacNabb</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>E. S. MacNabb</u>	

5.1.1

20.1.1

20.1.1.1

20.1.1.2

20.1.1.3

20.1.1.4

20.1.1.5

20.1.1.6

20.1.1.7

20.1.1.8

20.1.1.9

20.1.1.10

20.1.1.11

20.1.1.12

20.1.1.13

20.1.1.14

20.1.1.15

20.1.1.16

20.1.1.17

20.1.1.18

20.1.1.19

20.1.1.20

20.1.1.21

20.1.1.22

20.1.1.23

20.1.1.24

20.1.1.25

20.1.1.26

20.1.1.27

20.1.1.28

20.1.1.29

20.1.1.30

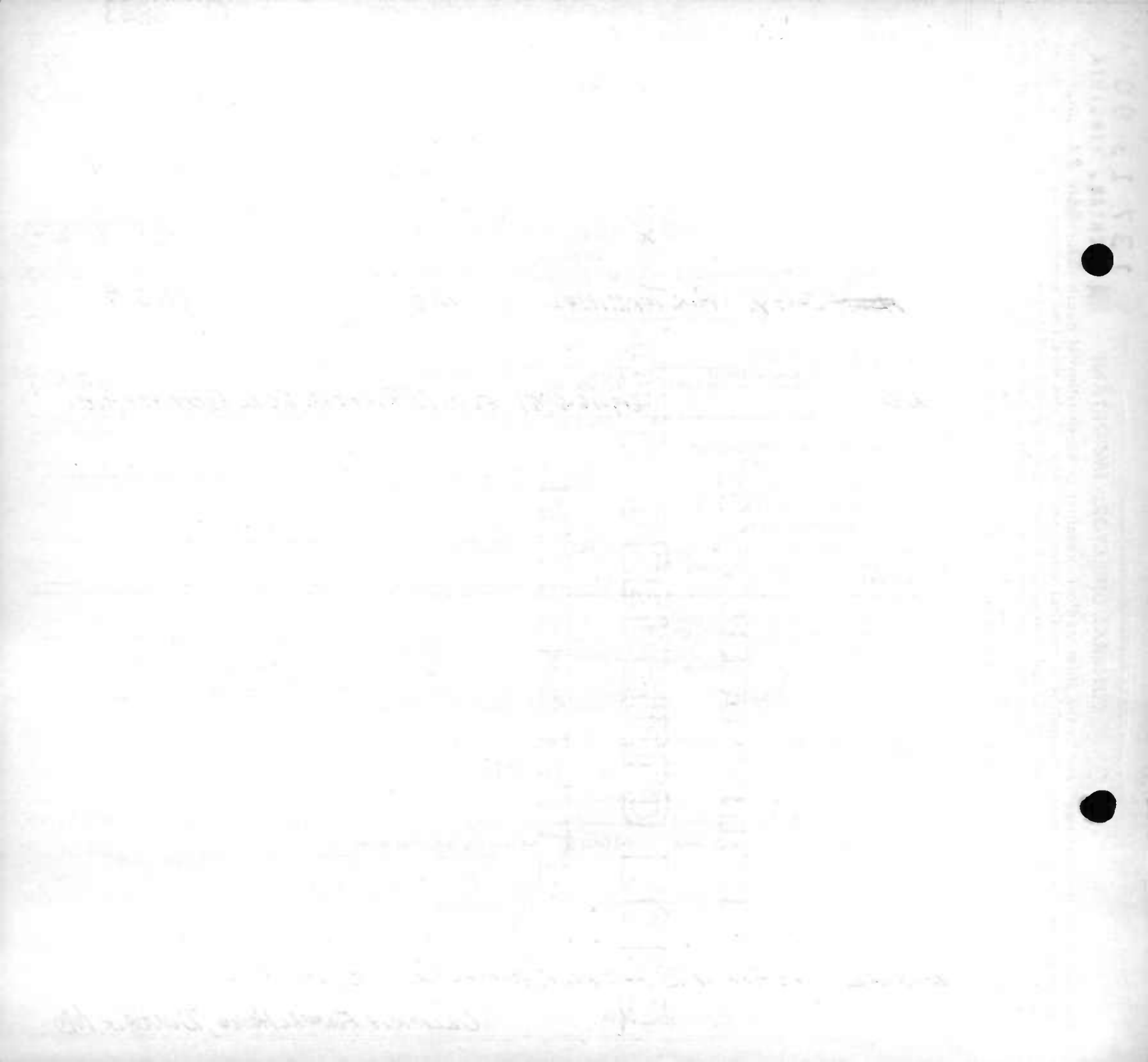
20.1.1.31

20.1.1.32

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 137 13 90 AS			
71 3623		BALTIMORE CITY HEALTH DEPARTMENT	
R-236		71 3623	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
RYCHTAR, VIRGINIA E.		APRIL 12, 1971 4:08 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland Balto.	
33		C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
JOHNS HOPKINS HOSPITAL		E. STREET AND NUMBER 2626 Edgemere Avenue	
5. SEX		6. RACE	
F		W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		4-6-24	
9. AGE (In years lost birthday)		10. UNDER 1 Yr. Months Days	
47			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
HEAT SECTY.		MD.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
AIR TERMINAL		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Melvin Coates		Jesse Rison	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		219-16-6967	
17. INFORMANT		ADDRESS	
EDW. M. RYCHTAR, 2626 Edgemere Ave.		21219	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
174X I		3 YRS 4 mos	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
II		METASTATIC CARCINOMA, BREAST	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) PERICARDIAL METASTASES WITH HEART FAILURE 1 mo	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
No		NONE	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MARCH 13 19 71 to APRIL 12 19 71 that (X) (we) last saw the deceased alive on APRIL 11 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Joseph Russ M.D.		4/12/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Joseph Russ, M.D.		The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		15 APR 71	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BAYVIEW NATIONAL Cem.		BALTO, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
APR 14 1971		Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Churchill Funeral Home, DUNDALK, MD.			



BIRTH NO.		REG. NO.	
B-300 71 3624		71 3624	
1. NAME OF DECEASED (Type or Print) Royce P. Battee		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 11 Year 71 Hour 4:00 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1209 Dundalk Avenue		3. DATE PRONOUNCED DEAD Month 4 Day 11 Year 71 Hour 4:00 p.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2646			
6. SEX male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
9. DATE OF BIRTH 5 SEPT. 1900	10. AGE (In years lost birthday) 70	E. STREET AND NUMBER 1209 Dundalk Avenue	
11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME GEORGE BATTEE	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE	14B. KIND OF BUSINESS OR INDUSTRY STEEL WRAPPING	15. MOTHER'S MAIDEN NAME JULIA KIMBERLY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII	17. SOCIAL SECURITY NO. 216-22-0332	18. INFORMANT MRS. R. E. TODD, 3704 MARLBOROUGH AVE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		21. AUTOPSY? (Yes or No) NO	
20A. DATE OF OPERATION 0	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED: 4/12/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 14 APR 71	24C. NAME of CEMETERY or CREMATORY OAK LAWN CEMETERY	24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS C.R. RICH FUNERAL HOME, DUNDALK, MD.	

Excerpt

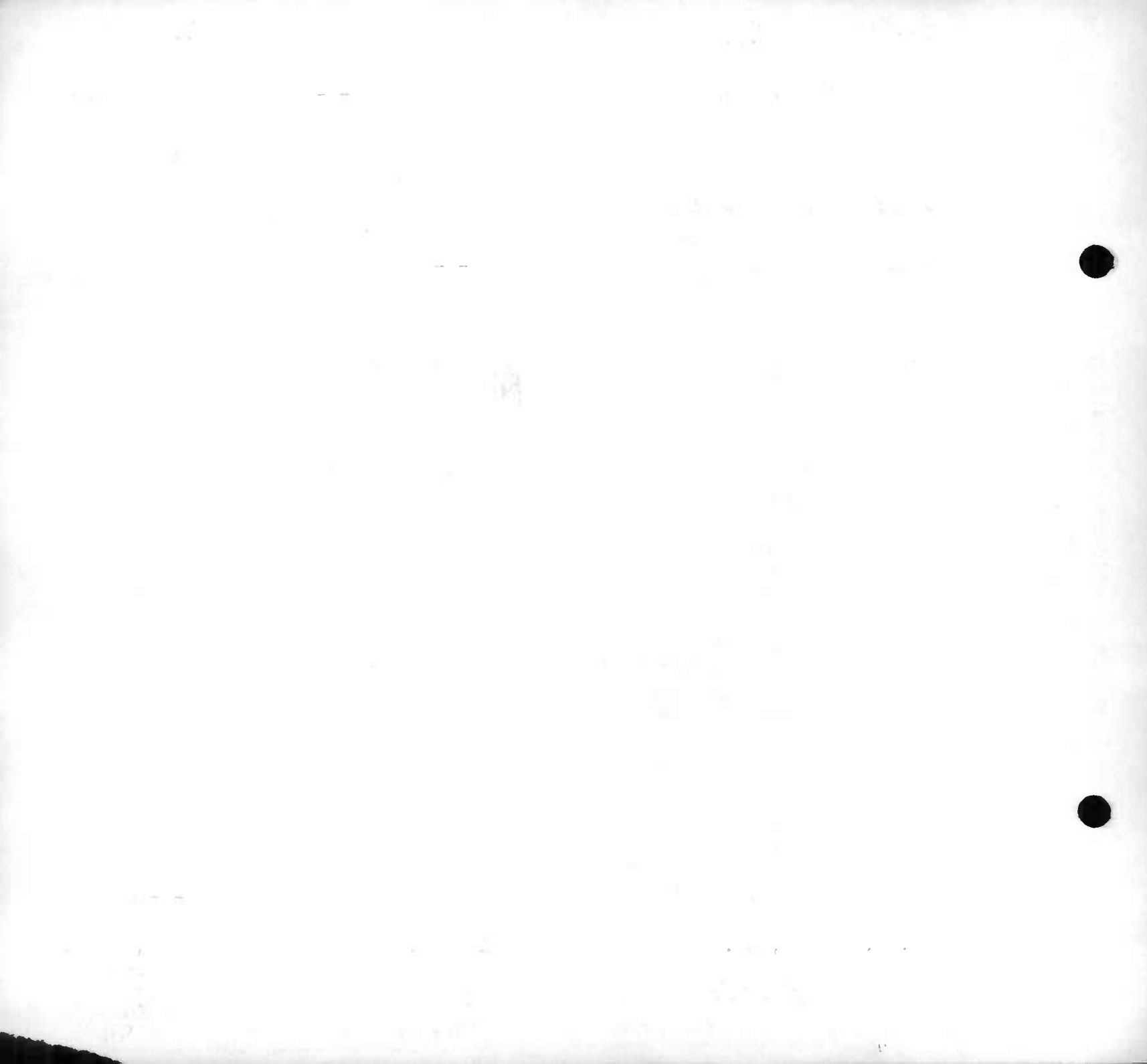
From the *Journal of the American Medical Association*

Published by the American Medical Association

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3625
1. NAME OF DECEASED (Type or Print) Spriggs, Baby "A"		2. DATE AND HOUR OF DEATH 4-3-71 9:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 15 Church Home and Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 301 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 258 S Spring St		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-71	9. AGE (In years last birthday) If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Louis Armstrong		14. MOTHER'S MAIDEN NAME Cynthia Garnet Spriggs		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. William Dorman, Jr.				23B. DATE SIGNED 4-4-71
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
J. W. Dorman, Jr.		3101 St. Paul Street Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATOR
4-12-71		ANATOMY BOARD OF MARYLAND		24D. LOCATION (If in Baltimore City, give exact location)
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		
APR 14 1971 Robert E. Taylor, M.D.		UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 3626	
J-520		71 3626		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs MARY JONES		2. DATE AND HOUR OF DEATH 4/4/71 5 15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore city 1901			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE Negr		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/17/1900		9. AGE (In years last birthday) 70		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) unknown	
12. CITIZEN OF WHAT COUNTRY US		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Nursing Home - Baltm H.H. Address above	
18. 250.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration pneumonia		36 hrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Hyperosmolar nonketotic Coma			
		(C) Diabetes mellitus		20 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Urinary Tract infection, old CVA.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/26/1971 to 4/4/1971 that (I) (we) last saw the deceased alive on 4/4/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. S. AL-IBRAHIM		23B. DATE SIGNED 4/4/71		23C. PHYSICIAN'S NAME (Type) M. S. AL-IBRAHIM M.D. Ch. S.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-71		24C. NAME OF CEMETERY OR CREMATORIAL SOCIETY	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

212 N. Cary - ddr 3-12-71

1
P-620 71 3627 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3627

BIRTH NO.		1. NAME OF DECEASED (Type or Print) John J. Powers		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 7 Year 71 Hour 10:15 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 422 S. Ann Street		3. DATE PRONOUNCED DEAD Month 3 Day 7 Year 71 Hour 10:15 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 202	
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		E. STREET AND NUMBER 422 S. Ann Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 571.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/8/71 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-71		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. NAME OF REGISTRAR	

James H. Smith

1871

1

71 3628

BALTIMORE CITY HEALTH DEPARTMENT

C-636

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3628

1. NAME OF DECEASED (Type or Print) JAMES CARTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 1, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 1, 1971 8:45 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1204			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH		10. AGE (In years last birthday) 45	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	E. STREET AND NUMBER 306 E. North Avenue
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS
19. 304.7 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Acute narcotism DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 1, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-71	
24C. NAME OF CEMETERY		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCMD

Letter from M.E.'s office

5-25-71

M.H.

Y 235

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3629

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM YOHSTEMARAH

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION, STREET ADDRESS OR LOCATION

00 1409 E. Fayette St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

4

10

1971

8:30 a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 301

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov 1, 1894

10. AGE (In years
lost birthday)

76

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1409 E. Fayette St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

231-01-3271

18. INFORMANT

Thomas E. Mohuck

ADDRESS

Same

19. 4/12/71

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/10/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-13-71

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1971

25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

Chroy O. W. Lson

ADDRESS

1000 Brantley Ave

Balt. Md.

Letter from M.E. & Office
4. 16. 11.

1
T.512

71 3630

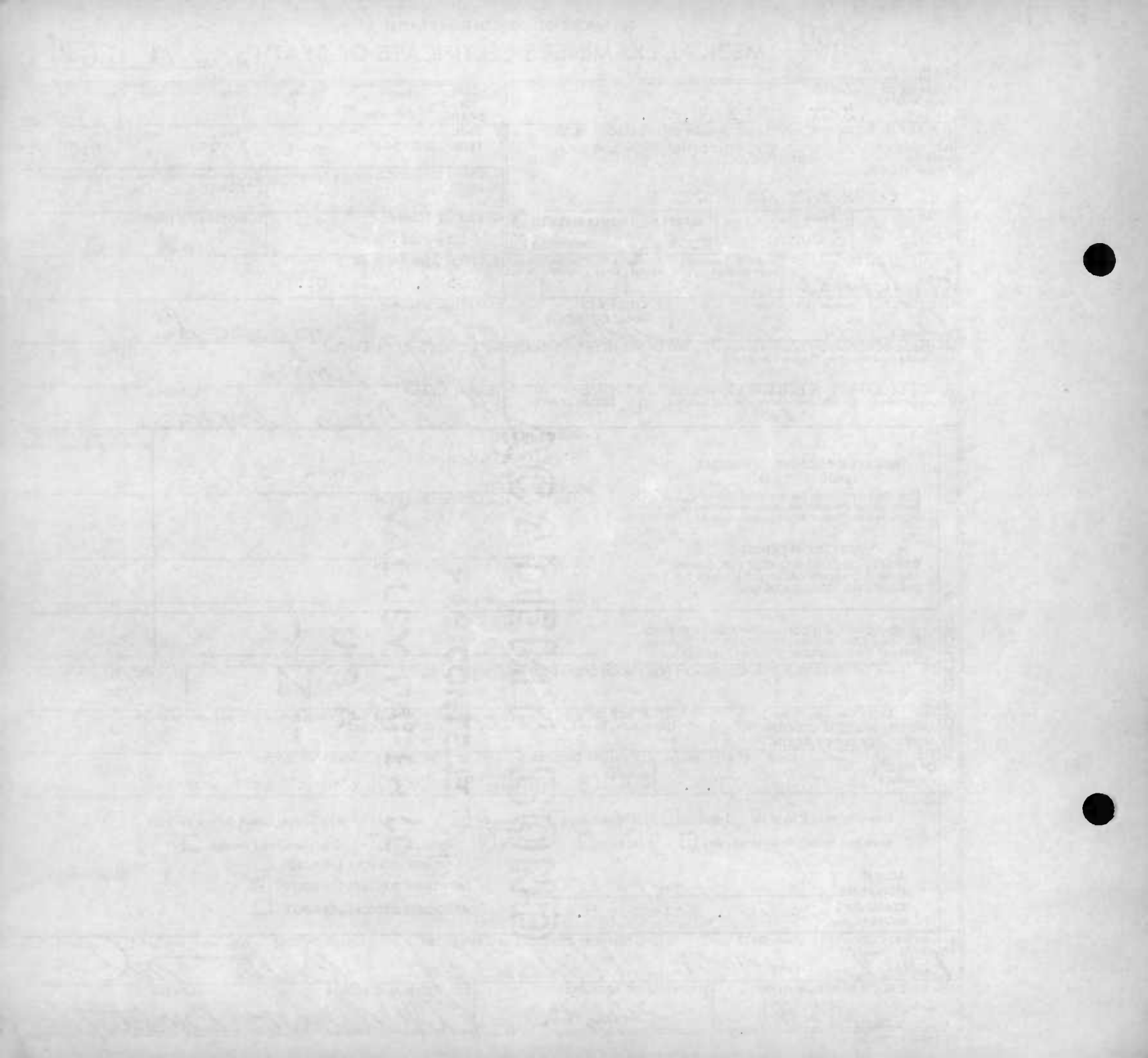
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3630

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEROY THOMPSON, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 6, 1971 9:05 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 1, 1953		10. AGE (In years last birthday) 17	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Thompson Sr		14. MOTHER'S MAIDEN NAME Jane Norris	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 301		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Jane Norris		ADDRESS	
19. E9631 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-6-71 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 4-10-71	
24C. NAME of CEMETERY or CREMATORY Mt Lebanon Cmt		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Ed Wilson 10001 Burnside Ave		ADDRESS	



1
A423

71 3631

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3631

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD ALSTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 6, 1971 5:01 P.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept. 4, 1898		10. AGE (In years lost birthday) 72	
11. BIRTHPLACE (State or foreign country) Littleton, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-09-7917	
18. INFORMATION Alvin Scott		ADDRESS Same	
19. 412.14 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 4/7/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 4-13-71	
24C. NAME OF CEMETERY or CREMATORY MT. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Chas. O. Wilson		ADDRESS 1000 Brantley Ave. Balto. Md.	

WALLEY FORM

P652

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3632

BIRTH NO. 65-26520

1. NAME OF DECEASED
(Type or Print)

KEVIN PRINGLE

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

44 Union Memorial Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

4

8

1971

11:05 p.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

901

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10-13-65

10. AGE (In years
last birthday)

5

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

822 Cator Ave.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Issac Pringle

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Baby

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Alice Bynum

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Issac Pringle

ADDRESS

same

19. E8147

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cranio-cerebral injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

800 Blk. Cator Ave. 901

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 4-8-71 6 p m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/9/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-13-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1971

25B. NAME OF REGISTRAR

E. J. Barber, M.D.

25C. FUNERAL DIRECTOR

E. J. Wilson

ADDRESS

1000 Brantley Ave.

02-10-20



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 71 3633									
D-400 71 3633		BIRTH NO.		1. NAME OF DECEASED (Type or Print) Dillakay, Elmer A. Sr.			2. DATE AND HOUR OF DEATH April 11, 1971 12:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 1222 W. Pratt St. Maryland Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital of Maryland				C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1222 W. Pratt St			1803		
5. SEX male	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/23/25		9. AGE (in years last birthday) 45		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR				10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Percy Dillakay				14. MOTHER'S MAIDEN NAME Bertha Jackson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 212-30-4069		17. INFORMANT Elmer A. Dillakay Jr. 1333 W. Pratt St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) 1621 I CAUSE OF DEATH Generalized Circumstances R+L				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Oat. Cell Ca. of R+L lung				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 12/8/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fair		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (justify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/11/71 to 4/11/71 and that (I) (we) lost saw the deceased alive on 4/11/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Therese J. M. D.				23B. DATE SIGNED 4/11/71					
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS University Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-71		24C. NAME of CEMETERY or CREMATORY CARVER MEM. PARK		24D. LOCATION LAUREL, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Carey St.			



CERTIFICATE AMENDED
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 3634**

BIRTH NO.

1. NAME OF DECEASED **THOMAS M. MIDDLETON JR.**
(Type or Print)

-ROGER-E.-MIDDLETON--

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
ADDRESS OR LOCATION

3. DATE PRONOUNCED DEAD Month Day Year Hour M.
4 10 1971 6:15a

38 University Hospital

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
Mass. V-18

6. SEX male 7. RACE negro 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN D. INSIDE CITY LIMITS?
Brookline YES ☐ NO ☐

9. DATE OF BIRTH **12-25-1946** 10. AGE (In years lost birthday) **24 25**

E. STREET AND NUMBER
11 Drummond St.

11. BIRTHPLACE (State or foreign country) **Boston, Mass.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME
Thomas Middleton Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer

15. MOTHER'S MAIDEN NAME
Theresa Wright

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes

17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS
023-36-2519 - Thomas Middleton - 11 Drummond St.

19. CAUSE OF DEATH
2815.0 S.S.#020-34-4270
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

(A) IMMEDIATE CAUSE **Multiple injuries**
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)
no

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **highway** 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? **Balto.-Wash. Expy. 600' so. of Hwy. 176**

22D. TIME OF INJURY (APPROX.) **4-10-71 5:20 a.m.** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR?
Passenger in auto-fixed object collision.

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type) **Isidore Mihalakis, M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **4/10/71**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **4-14-71** 24C. NAME OF CEMETERY or CREMATORY **Mt. Hope** 24D. LOCATION (City, town, or county) (State) **Boston, Mass.**

25A. DATE REC'D BY HEALTH DEPT. **APR 14 1971** 25B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 25C. FUNERAL DIRECTOR ADDRESS **Davis F/H - Roxbury, Mass.**

Davis Funeral Home
89 Walnut Ave.
Roxbury, Mass. 02119

Burial and Transit permit issued by Maryland Medical Examiners Office showing name of Roger E. Middleton is erroneous. Correct name is Thomas M. Middleton Jr. You are authorized by me and Sidney M. Norton, Baltimore City Registrar of Vital Statistics to amend certificate to show correct name.

Russell S. Fisher, M.D.
Chief Medical Examiner
State of Maryland.

Corrected by M.E.'s office
Corrected by V.S. 153
4-19-71 M.H.
5-7-71 M.H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

3635

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RODNEY QUALLS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

6:15a

M.

5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)

A. STATE

B. COUNTY

Massachusetts

V-18

6. SEX

male

7. RACE

negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Brookline

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

3-9-1949

10. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

32 Center St.

11. BIRTHPLACE (State or foreign country)

Cambridge, Mass.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harvey Qualls

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Neborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Vivian Harris

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

023-36-2510

18. INFORMANT

ADDRESS

Harvey Qualls - Dorchester, Mass.

19.

E81310

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A.

DATE OF OPERATION

2

20B.

CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

highway

22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?

Balto-Wash. Expressway 600' so. of Hwy.

22D.

TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

4-10-71

5:20 a.m.

22E.

INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver in auto-fixed object collision.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/10/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-15-71

24C. NAME OF CEMETERY or CREMATORY

Cambridge City

24D. LOCATION

(City, town, or county)

(State)

Cambridge, Mass.

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1971

25B. NAME OF REGISTRAR

Robert E. Kelly, R.D.

25C. FUNERAL DIRECTOR

ADDRESS

E. S. Johnson - Cambridge, Mass

1-9-1949

Harvey Swails

U.S.A.

Cambridge, Mass.

Vivian Harris

Robert

023-36-1510 Harvey Swails - Rochester, Mass.

No

Swails is Robert

Swails

4-12-49

Cambridge City

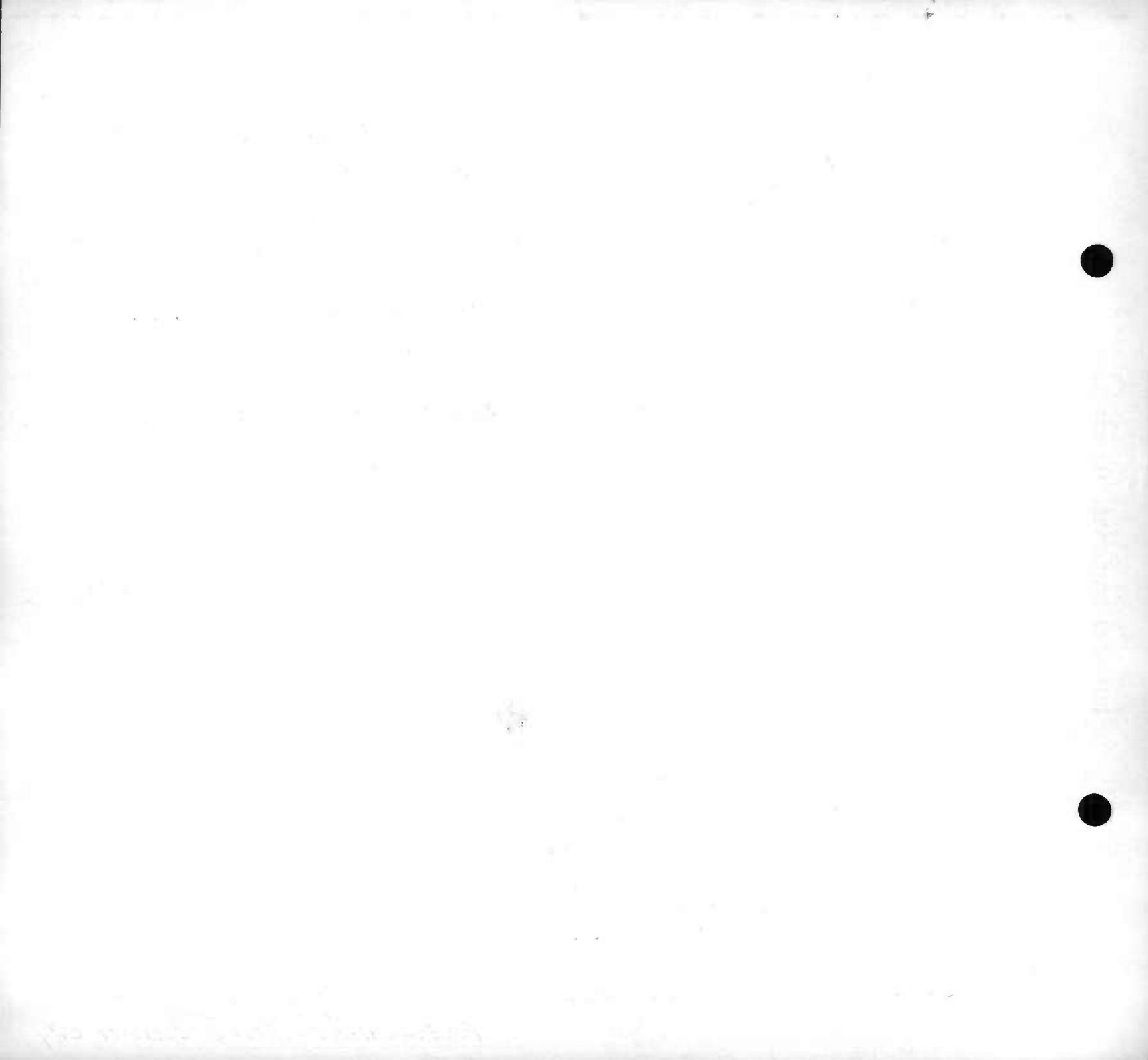
Cambridge, Mass.

E. B. Johnson - Cambridge, Mass.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.		71 3636	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Sister Mary Berchmans Poole</p>				<p>2. DATE AND HOUR OF DEATH 4-13-71 7:40 A.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Jenkins Memorial Hospital 1000 Caton Avenue Baltimore, Md. 21229</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md/ B. COUNTY Frederick BALTIMORE 5300</p> <p>C. CITY OR TOWN Catonville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 700 Academy Road</p>			
<p>5. SEX Female</p>		<p>6. RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 3-13-1900</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY School</p>		<p>11. BIRTHPLACE (State or foreign country) Frederick, Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Ernest Poole</p>				<p>14. MOTHER'S MAIDEN NAME Anna Topper</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown</p>		<p>16. SOCIAL SECURITY NO. 219-54-2750</p>		<p>17. INFORMANT Jenkins Memorial 1000 Caton Ave. 21229</p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 23091 CAUSE OF DEATH</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2</p>			
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(A) IMMEDIATE CAUSE myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) arteriosclerotic cor. art. dis. DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) no</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from July 19 70 to 13 Jan 19 71 that (I) (we) last saw the deceased alive on 13 Jan 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE Laurence R. Gallager, M.D.</p>				<p>23B. DATE SIGNED 13 Apr 71</p>		<p>23C. PHYSICIAN'S NAME (Type) Laurence R. Gallager, M.D.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>				<p>24B. DATE APRIL 15 71</p>		<p>24C. NAME OF CEMETERY OR CREMATORY MT. DE SALES</p>	
<p>24D. LOCATION (City, town, or county) (State) CATONVILLE MD.</p>				<p>25A. DATE REC'D BY HEALTH DEPT. APR 14 1971</p>			
<p>25B. NAME OF REGISTRAR Robert E. J. M.D.</p>		<p>25C. FUNERAL DIRECTOR HOWARD COUNTRY ADDRESS FUNERAL HOME - WITKE CLICITY CITY</p>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
71 3637									
B-623 71 3637									
1. NAME OF DECEASED (Type or Print) LOUISE LULA BRIGHT					2. DATE AND HOUR OF DEATH 4/12/71 4:45 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1303				
FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL 2600 Liberty Hgts. Ave.					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F					6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 81		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Balto., Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 214-03-4826		17. INFORMANT Mrs. Eleanor Tyler-daughter		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E8841X					19. CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF: BED RIDDEN (B) FRACTURE, HIP, (R) (C) Generalized Arteriosclerosis				
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (If yes, notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2426 WOODBROOK AVENUE 1303		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 4 11 71					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell from the bed		
22. I certify that (I) (this hospital) attended the deceased from 4/11 1971 to 4/12 1971 and that (I) (we) last saw the deceased alive on 4/12 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Seiderio L. Hebron, Jr.					23B. DATE SIGNED 4/12/71		23C. PHYSICIAN'S NAME (Type) SEIDERIO L. HEBRON, JR.		
23D. ADDRESS 2600 Liberty Hgts. Ave. Balto., Md. 21215					23E. FUNERAL DIRECTOR Mary-Elizabeth Law				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4-15-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore9 Md.
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971					25B. NAME OF REGISTRAR James E. Varley, R.A.		25C. FUNERAL DIRECTOR ADDRESS 802 Madison Avenue		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Flora Jones		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 12 Year 71 Hour 2:50 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1607 Argyle Ave.		3. DATE PRONOUNCED DEAD Month 4 Day 12 Year 71 Hour 2:50 a.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1402			
6. SEX female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 7, 1905		E. STREET AND NUMBER 1607 Argyle Avenue	
11. BIRTHPLACE (State or foreign country) Accomac Co. Va.		13. FATHER'S NAME William Mason	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Daisy Whorton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Hypertensive and arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/12/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/17/71	24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	24D. LOCATION (City, town, county) (State) Balto. Md.
25A. DATE RECEIVED BY HEALTH DEPT. APR 14 1971	25B. NAME OF REGISTRAR E. J. Bailey, M.D.	25C. FUNERAL DIRECTOR Williams Funeral Home	ADDRESS 319 N. School St.

10

Sept 1902

James Co. Va.

For service

to

William Mason

Tracy Martin

Miss Elizabeth Martin

James Co. Va.

VALLEY

VALLEY

Sept 1902

James Co. Va.

Elizabeth Martin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 3639		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3639	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARIE JOHNSON		4-13-71 1:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. 725 George St. B. COUNTY		C. CITY OR TOWN Baltimore	
Montebello State Hospital Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 725 George St.	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-93	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) San Antonio, Texas	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 216-05-2285		17. INFORMANT Mrs Mabel Smith	
18. CAUSE OF DEATH		ADDRESS 1738c Druid Hill Ave			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Bilateral Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Dermatomyositis DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-1-71 to 4-13-71 1971, that (I) (we) last saw the deceased alive on 4-13-71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jack I. Stern, M.D.		23B. DATE SIGNED 4-13-71			
23C. PHYSICIAN'S NAME (Type) JACK I. STERN		23D. ADDRESS MONTEBELLO STATE HOSP BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-71		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR R. E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Moreland Dyett F. H.		25D. ADDRESS 1701 Lawrence St			

BALTIMORE CITY HEALTH DEPARTMENT				71 3640			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 3640			
BIRTH NO. <u>65-17906</u>							
1. NAME OF DECEASED (Type or Print) <u>Ken McDaniels</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>4</u> Day <u>11</u> Year <u>71</u> Hour <u>5:55 PM.</u>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u>				3. DATE PRONOUNCED DEAD Month <u>4</u> Day <u>11</u> Year <u>71</u> Hour <u>5:55 PM.</u>			
				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1513</u>			
6. SEX <u>male</u>		7. RACE <u>Negro</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>	
9. DATE OF BIRTH <u>July 10, 1965</u>		10. AGE (In years last birthday) <u>5</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <u>4004 Oswego Ct.</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Mynus McDaniel</u>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Axcie McDaniel</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT <u>Mynus McDaniel</u> ADDRESS <u>4004 Oswego Ct. 21215</u>			
19. CAUSE OF DEATH <u>E814.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple injuries</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>no</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>STREET</u>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>2500 Shirley Ave.</u> <u>1513</u>			
22D. TIME OF INJURY (APPROX.) Month <u>4</u> Day <u>11</u> Year <u>71</u> Hour <u>2:00 PM.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Subject was hit by taxi while crossing street.</u>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D. EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u> DATE SIGNED <u>4/12/71</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-15-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Star Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>John, Md.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morton & Dyett F. H. 1701 Laurens St 21217</u>			

CS 17506

July 17, 1955

Mr. J. Edgar Hoover

U. S. A.

Washington, D. C.

Dear Sir:

Enclosed for you are

two copies of a letterhead memorandum

Handwritten signature

Sincerely,

100-1

Western Security Committee

July 17, 1955

Western Security Committee, 1500 Pennsylvania Avenue, N.W., Washington, D. C. 20004

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 71 3641		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3641	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Williams, James O.		4-12-71		3:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
42 Sinai Hospital			Md. 1530 Moreland Ave #16/503		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1530 Moreland Ave # 16		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
M	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-6-18	53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Bethlehem Steel		Franklin Co, N.C.	
13. FATHER'S NAME.			14. MOTHER'S MAIDEN NAME		
William A. Williams			Alice Williams		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		237-24-1503		Marie Williams 1530 Moreland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			Terminal Carcinoma		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			General Metastasis to Brain		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Ca of left lung		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-28-71 to 4-12-71 that (I) (we) last saw the deceased alive on 4-12-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
A. Ong 9110			4-12-71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
ANTONIO C. ONG, MD			Sinai Hosp. of Baltimore, Md 21201		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4-15-71		Arlington Mem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 14 1971		John E. Taylor, JR.		Marion Dyett F.H. 1701-1700000	

S-361

71

3642

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

3642

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Novella Satterfield		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 11 71 8:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 11 71 8:30 a.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/9/1891		10. AGE (In years last birthday) 79	
11. BIRTHPLACE (State or foreign country) Roxboro, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 242-58-3592B	
18. INFORMANT James Satterfield; 3050 Arunah Ave. 21216		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/12/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/15/71	
24C. NAME OF CEMETERY or CREMATORY Lawson Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Roxboro, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME		ADDRESS 1701-31 Laurens St., Balto., Md. 21217	

SP82

100-001

x

x

79

10/18/81

Lee Thomas

USA

North Carolina

Anna Thomas

242-28-3292B James Satterfield; 3020 Arunah Av

olina

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3643

BIRTH NO. W-414

1. NAME OF DECEASED (Type or Print) Alphonso Woolfolk				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>4</u> Day <u>11</u> Year <u>71</u> Hour <u>2:55</u> p.m. Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>				3. DATE PRONOUNCED DEAD Month <u>4</u> Day <u>11</u> Year <u>71</u> Hour <u>2:55</u> p.m.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1303</u>							
6. SEX <u>41 male</u>	7. RACE <u>Negro</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>May 29, 1929</u>		10. AGE (In years last birthday) <u>41</u>		E. STREET AND NUMBER <u>1222 West North Avenue</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Robun Woolfolk</u>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Gas & Elec.</u>		15. MOTHER'S MAIDEN NAME <u>Edna Woolfolk</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <u>214-24-7599</u>		18. INFORMANT ADDRESS <u>Edna Woolfolk 2864 W. Garrison Ave. 21215</u>			
MEDICAL CERTIFICATION 19. <u>E887X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Subdural and subarachnoid hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Unk.</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>Unk.</u>			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>Unk.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Subject apparently fell</u>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D. EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-15-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morton & Dyett F. H. 1701 Laurens St. 21217</u>			

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

101, 102

FUNERAL DIRECTOR: IMPORTANT

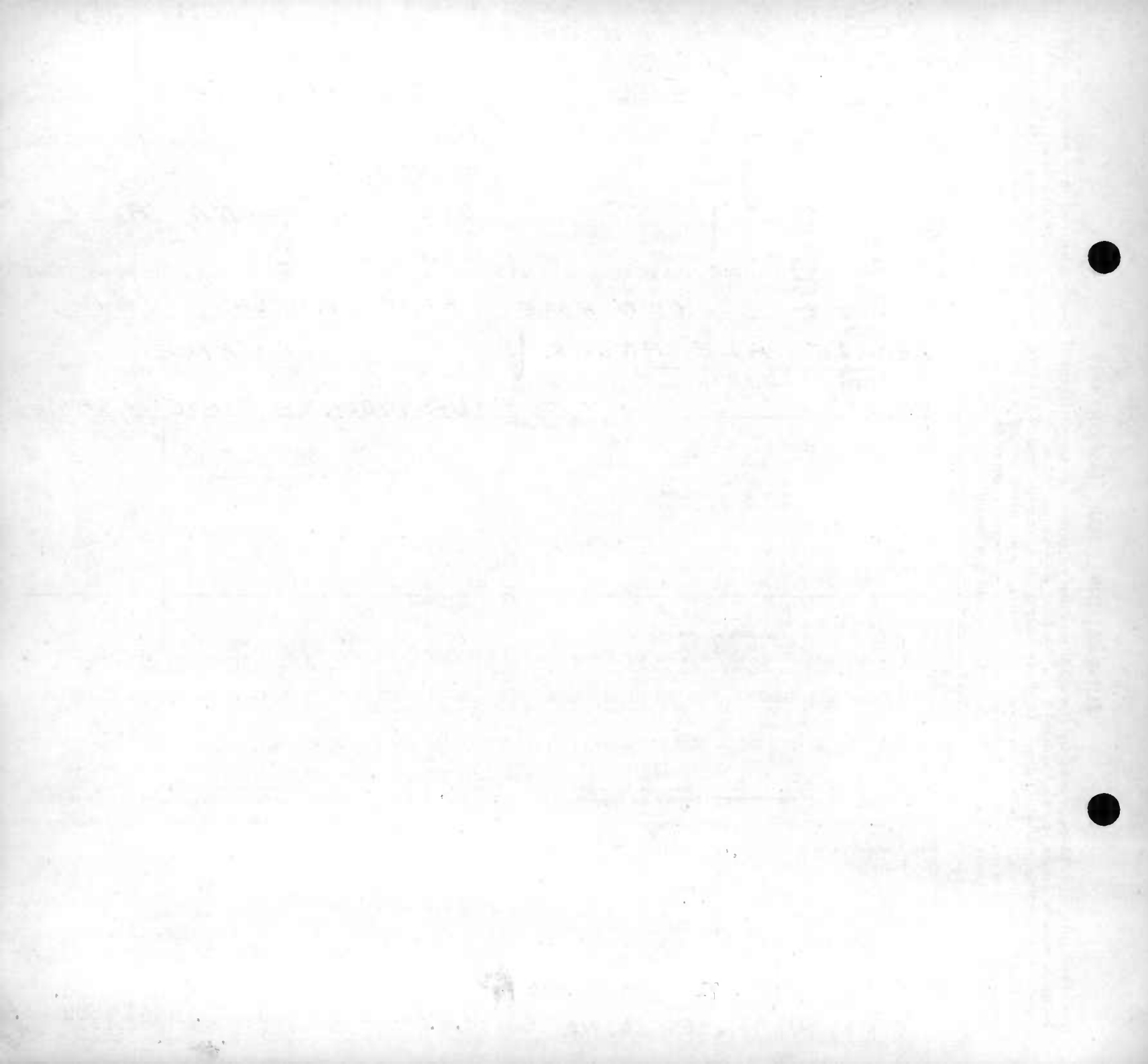
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3644</u>	
BIRTH NO. <u>71 3644</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Joseph A. Krimm</u>		2. DATE AND HOUR OF DEATH <u>April 12, 1971</u> <u>1:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2714</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4800 Keswick Road</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>3-18-1897</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd. Tax Agent Assessor Western Md.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RR.</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>A. John Krimm</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Albrecht</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>			
16. SOCIAL SECURITY NO. <u>725-16-5592</u>		17. INFORMANT <u>Mrs. Catherine K. Krimm</u> ADDRESS <u>Same</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Occlusion</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>Several</u>	
(C) <u>a Hypertension</u>				<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Monday</u> 19 <u>54</u> to <u>Present</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Warde B. Allan</u>				23B. DATE SIGNED <u>4-13-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Warde B. Allan M.D.</u>				23D. ADDRESS <u>6 E. Eager Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-16-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Gardens</u>	
24D. LOCATION (City, town, or county) <u>Timonium, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>			
25B. NAME OF REGISTRAR <u>R. E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3645	
CERTIFICATE OF DEATH					
BIRTH NO. 71 3645					
1. NAME OF DECEASED (Type or Print) CORRIE ROE			2. DATE AND HOUR OF DEATH Apr 14 1971 5:30A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2712		
FULL NAME OF HOSPITAL OR INSTITUTION 90 EDGEWOOD NURSING HOME			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 6022 BELLONA AVE.		
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 29 1894	9. AGE (In years last birthday) 96	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ERIE, KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME GEORGE ALEXANDER			14. MOTHER'S MAIDEN NAME VAILE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-548204	17. INFORMANT ADDRESS DR. MAURICE A. ROE (SAME)		
18. 4-12-41		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12+ yrs	
		(B) Arteriosclerotic cardiovascular		12+ yrs	
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-2 1968 to 4-14 1971 , that (I) (we) last saw the deceased alive on Apr 10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer MD				23B. DATE SIGNED 4-14-71	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER MD				23D. ADDRESS 6100 YORK RD BALTO MD 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4/14/71		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR R. E. Farber, MD.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



1
L000

BALTIMORE CITY HEALTH DEPARTMENT

71 3646 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

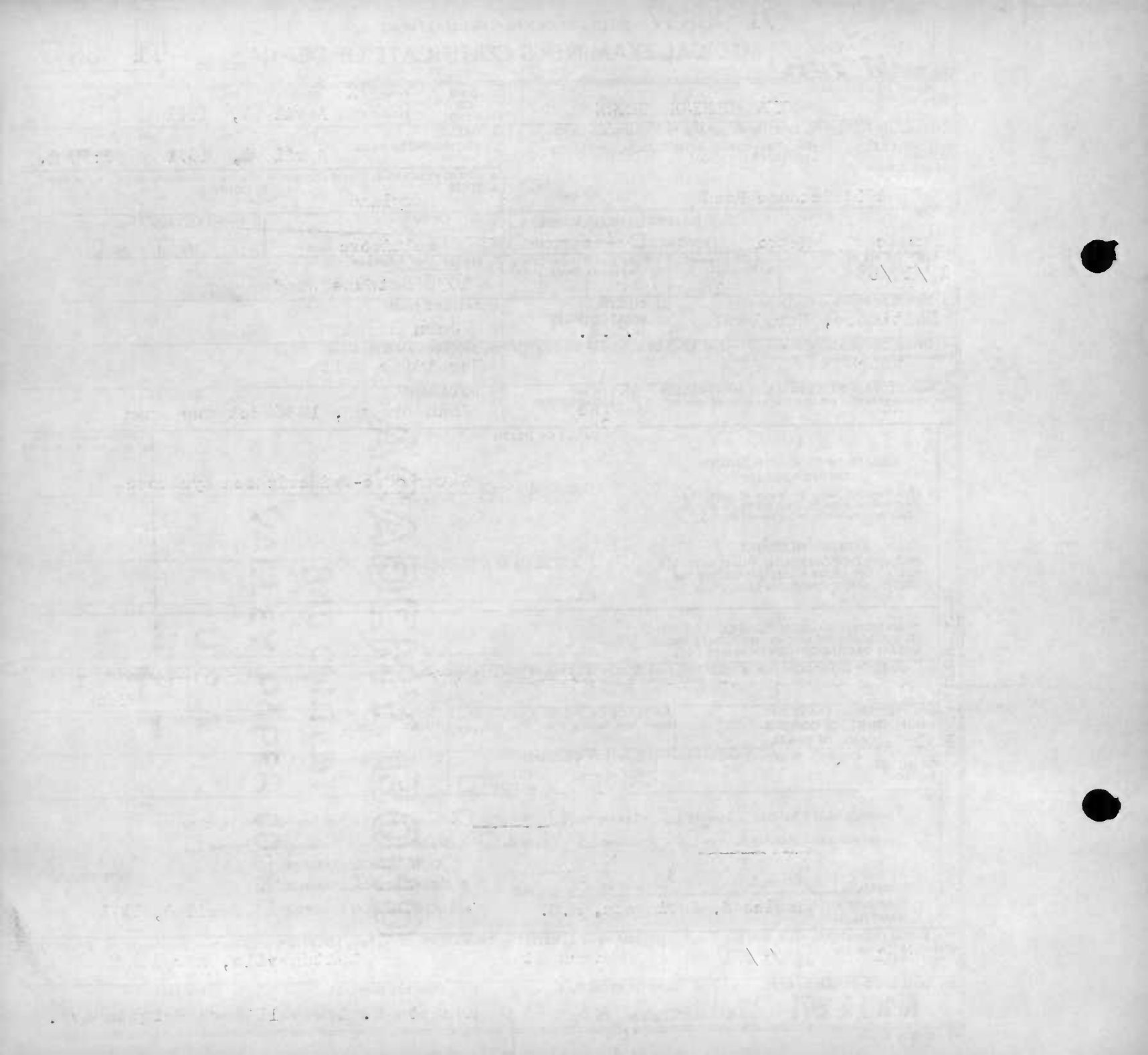
REG. NO. 71 3646

BIRTH NO.		2. DATE OF DEATH		Month		Day		Year		Hour	
1. NAME OF DECEASED (Type or Print)		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		4		12		71		10:28 a.m.	
Mary Alice Lee											
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4		12		71		10:28 a.m.	
42 Sinai Hospital											
6. SEX		7. RACE		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years lost birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER					
12-22-22		48				2500 Loyola Southway					
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME							
Edgefield, S.C.		U.S.A.		GRADY OUTTS							
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MARDEN NAME							
Housewife		Home		HELEN BURTON							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS					
NO		220-14-7210		WINTON LEE		2500 Loyola Southway					
19. 412.4 I		CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arteriosclerotic cardiovascular disease									
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:									
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:									
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED								21. AUTOPSY? (Yes or No)	
2										yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
23.											
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER		DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER		4/12/71					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
BURIAL		4-17-71		CARVER MEMORIAL PARK		LAUREL MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
APR 14 1971		R. E. Faber, M.D.		CALVIN B. SCRUBBS		1412 E. Preston St.					

6/25/71 - Letter from M.E.O.

Lfc.

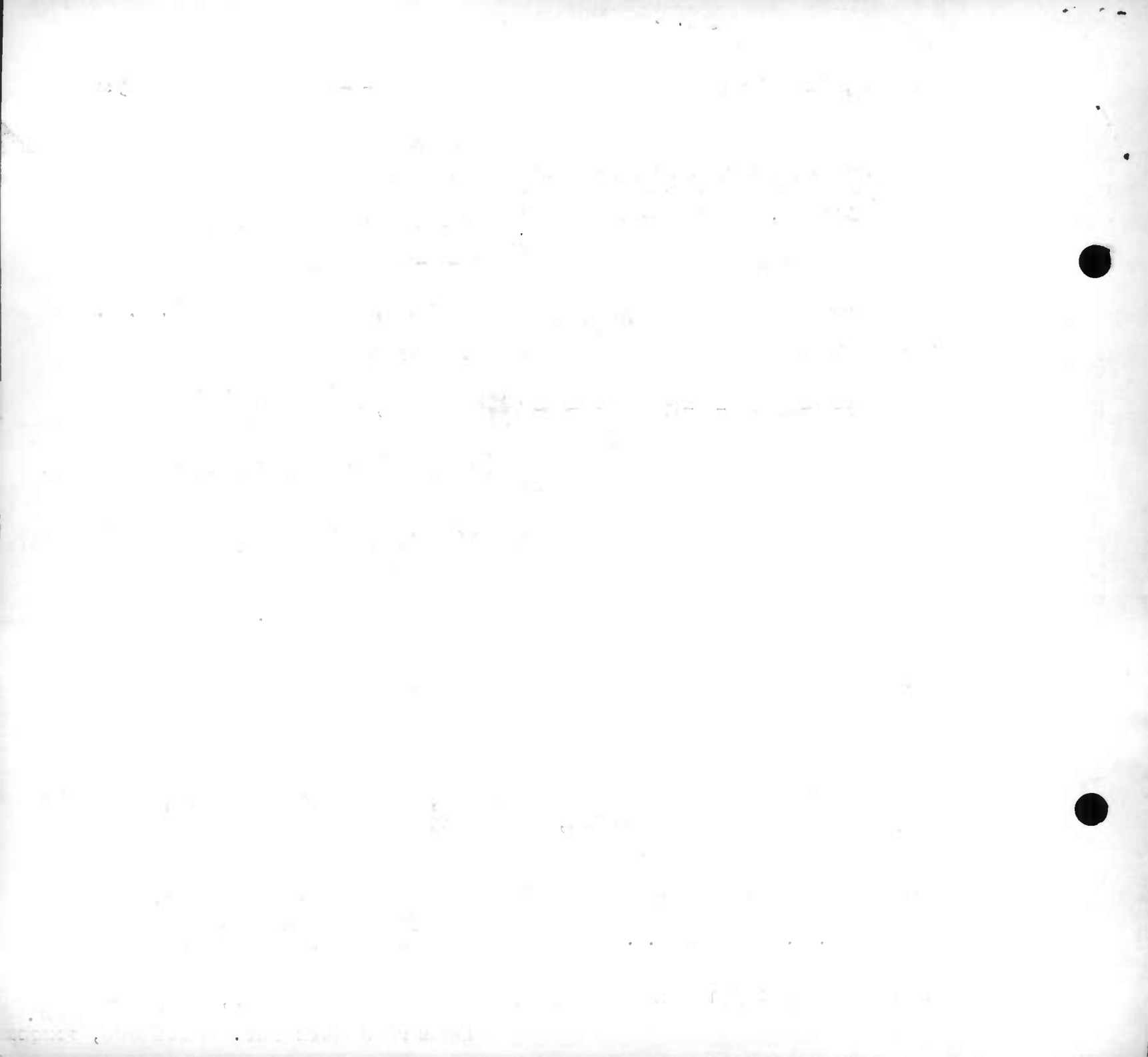
BIRTH NO. <u>B-650</u> <u>68-24221</u>		71 3647 BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. <u>71 3647</u>	
1. NAME OF DECEASED (Type or Print) <u>NINA DENISE BROWN</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>April</u> Day <u>4</u> Year <u>1971</u>		Hour <u>M.</u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1038 Bethune Road</u>				3. DATE PRONOUNCED DEAD Month <u>April</u> Day <u>4</u> Year <u>1971</u>		Hour <u>2:50 A.</u> M. <u>M.</u>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2562</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>Female</u>		7. RACE <u>Negro</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>1038 Bethune Road</u>	
9. DATE OF BIRTH <u>12/19/68</u>		10. AGE (In years last birthday) <u>2</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brown</u>		14. MOTHER'S MAIDEN NAME <u>Geroldine Smith</u>		15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>None</u>		19. INFORMANT <u>John Brown, 1038 Bethune Road</u>		ADDRESS	
19. <u>036.11</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Waterhouse-Fridericksen syndrome</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) _____			
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>Yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 4, 1971</u>	
EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Western Star</u>		24D. LOCATION (City, town, or county) (State) <u>Gattonsville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kenneth H. Law</u>		ADDRESS <u>4611 Park Heights Ave.</u>	



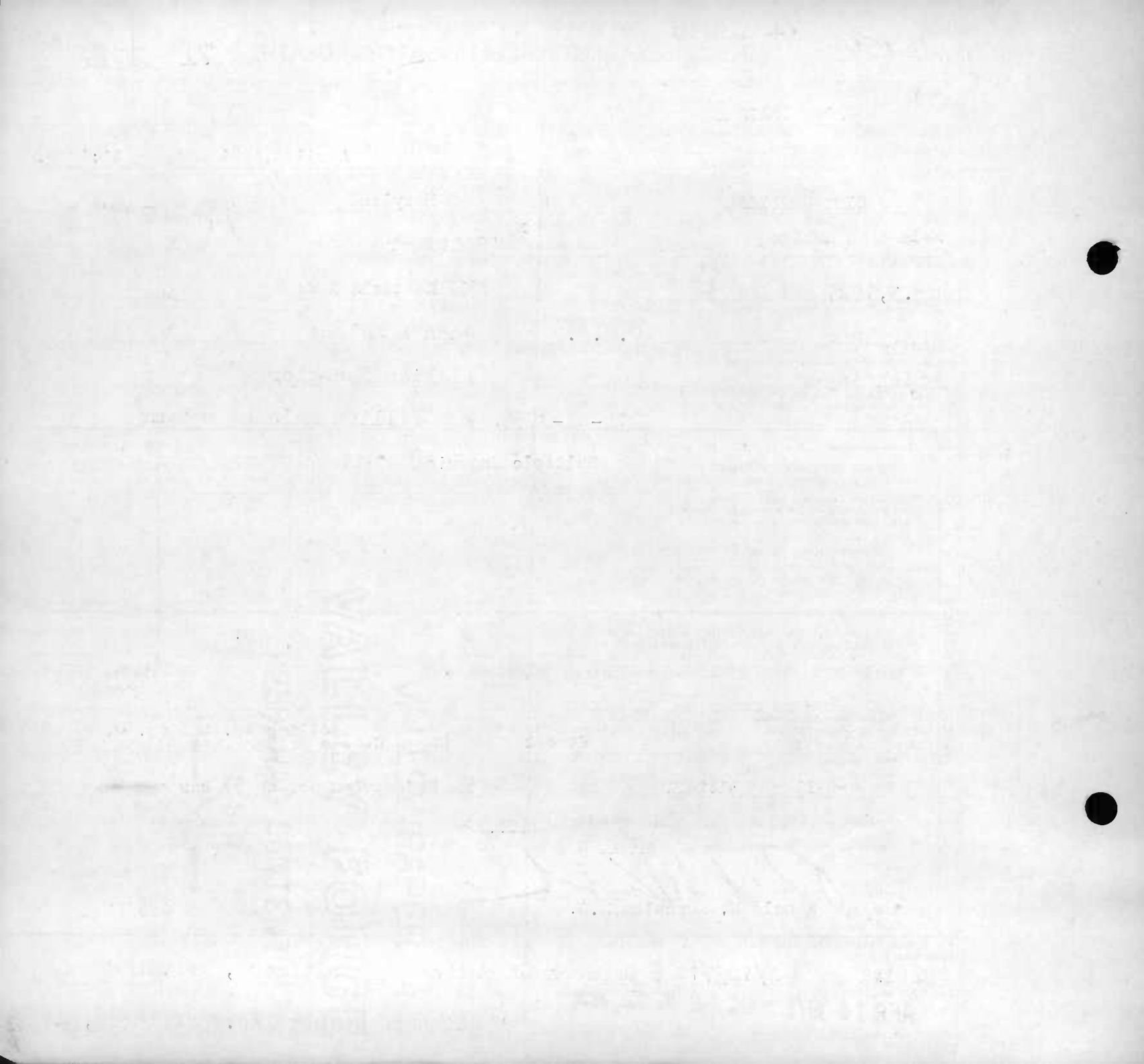
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>E-263</u> 71 3648				BAPTIST CITY HEALTH DEPARTMENT		REG. NO. <u>71</u> 3648	
1. NAME OF DECEASED (Type or Print) <u>ECKHART, Gary Milton</u>				2. DATE AND HOUR OF DEATH <u>4-9-71</u> <u>3:40</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2642</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4408 Bowley's Lane</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-48</u>	9. AGE (In years last birthday) <u>22</u>	10. Under 1 Yr. Months <u>18</u>	11. Under 24 Hrs. Days <u>18</u>	12. Under 24 Hrs. Hours <u>18</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Milton Eckhart</u>			
14. MOTHER'S MAIDEN NAME <u>Irene Rogers Rodrick</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>3-21-69 to 2-18-71</u>			
16. SOCIAL SECURITY NO. <u>212-48-49-87</u>				17. INFORMANT <u>VA Hospital Records</u> ADDRESS <u>Baltimore, Maryland 21218</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Fulminant Viral Hepatitis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Drug addiction (abuse)</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>?</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>About 2 years</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>March 22,</u> 19 <u>71</u> to <u>April 9,</u> 19 <u>71</u> that <u>SD</u> (we) last saw the deceased alive on <u>April 9,</u> 19 <u>71</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. (<u>XX</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C. L. Cromwell, MD</u>				23B. DATE SIGNED <u>4/9/71</u>		23C. PHYSICIAN'S NAME (Type) <u>C. L. CROMWELL M.D.</u>	
23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		24A. BURIAL CREMATION, REMOVAL (Specify)					
24B. DATE <u>4/12/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenwood Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>APR 14 1971</u>	
25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore, Maryland</u>					



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
JOHN MALONE		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		April 6, 1971 11:40 P.M.		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Male		White				Aug. 5, 1927		43		Maryland		U.S.A.		John L. Malone		Brick Layer				Lillian Spangler		No		214-24-3799		Mrs Lillian Malone		Same	
19. <u>58147</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH		Multiple Injuries		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:		(B)		DUE TO, OR AS A CONSEQUENCE OF:		(C)																									
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).																																					
		20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes																															
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		Rolling Rd. 483 ft. W. of Caton Circle Drive		22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?		Pedestrian struck by car																									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS																							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/8/71		Burial		4/10/71		Gardens Of Faith		Baltimore, Maryland		APR 14 1971		Leonard J. Ruck Inc. Baltimore, Md																					



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)P.
IDA CAPP2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 7, 1971

12:05 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2605

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒No ☐

9. DATE OF BIRTH

Dec. 14, 1890.

10. AGE (In years
last birthday)

80

x81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

324 S. Kane Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward L. Throne

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ella Weatherstein

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

219-52-9531

18. INFORMANT

Mr. Francis C. Capp

ADDRESS

(Same)

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Cerebral Infarction

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/8/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/12/71.

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1971

25B. NAME OF REGISTRAR

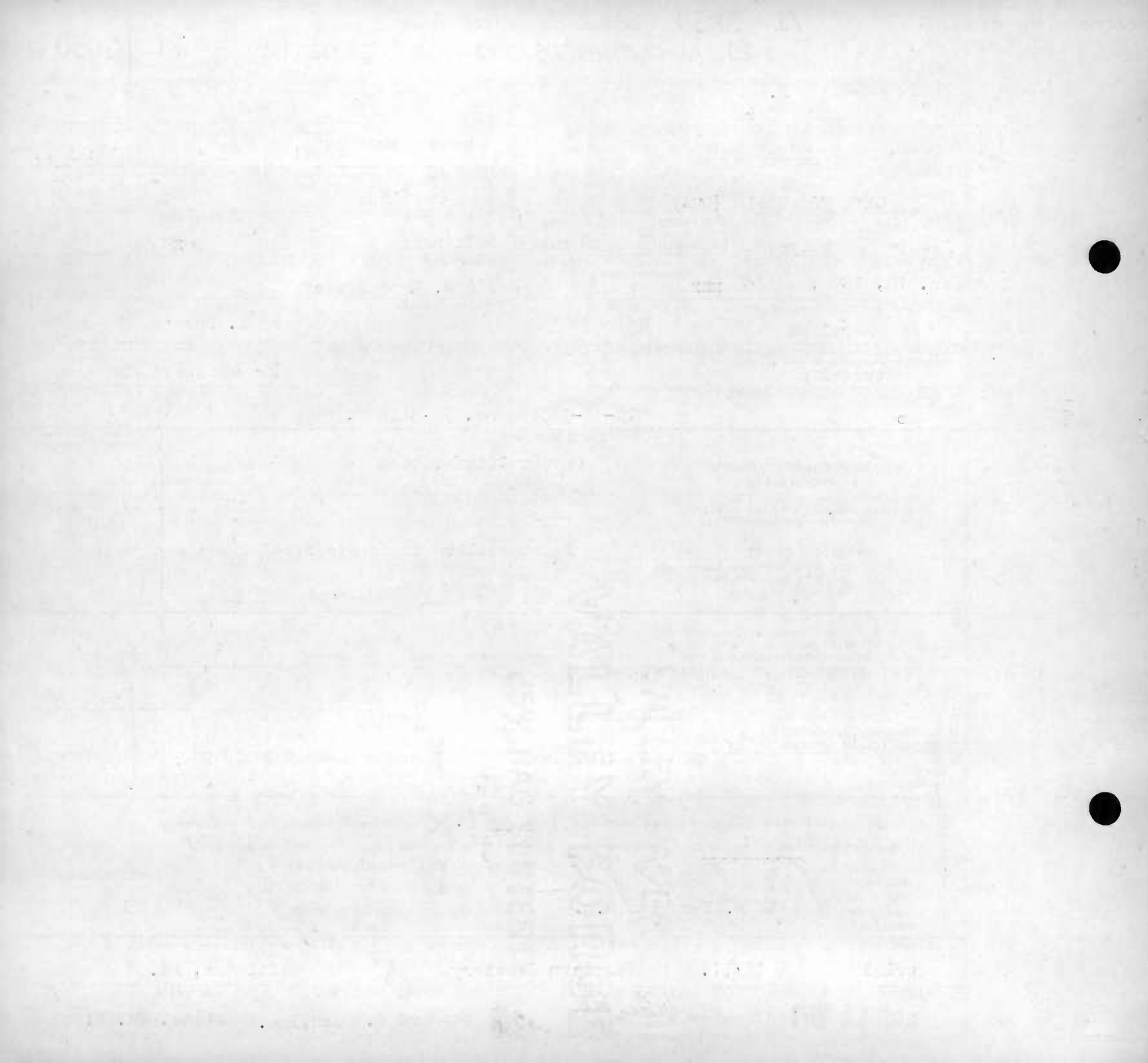
Robert E. Gabel, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc.

ADDRESS

Balto. Md. 21214

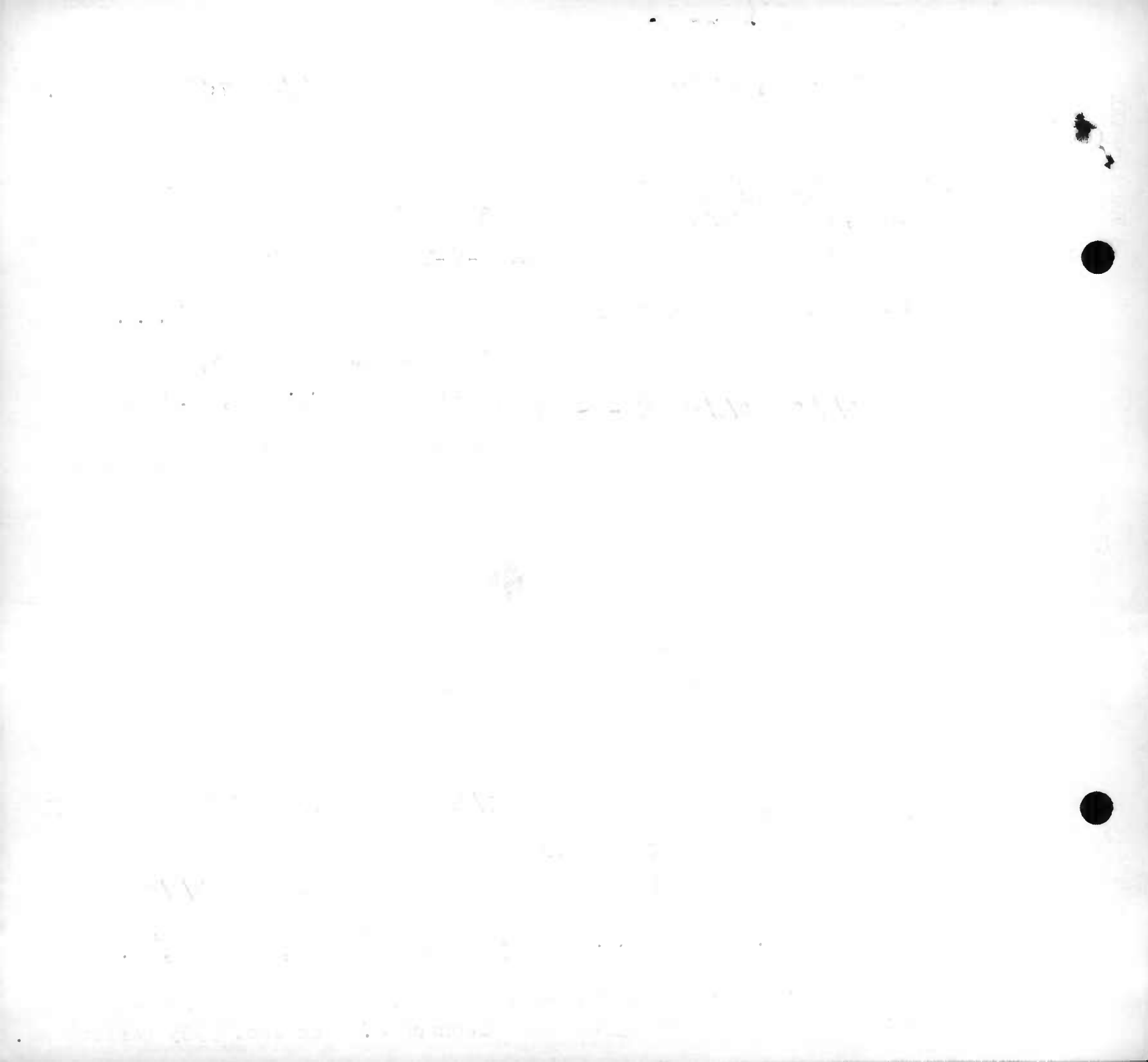


FOR APPROVAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

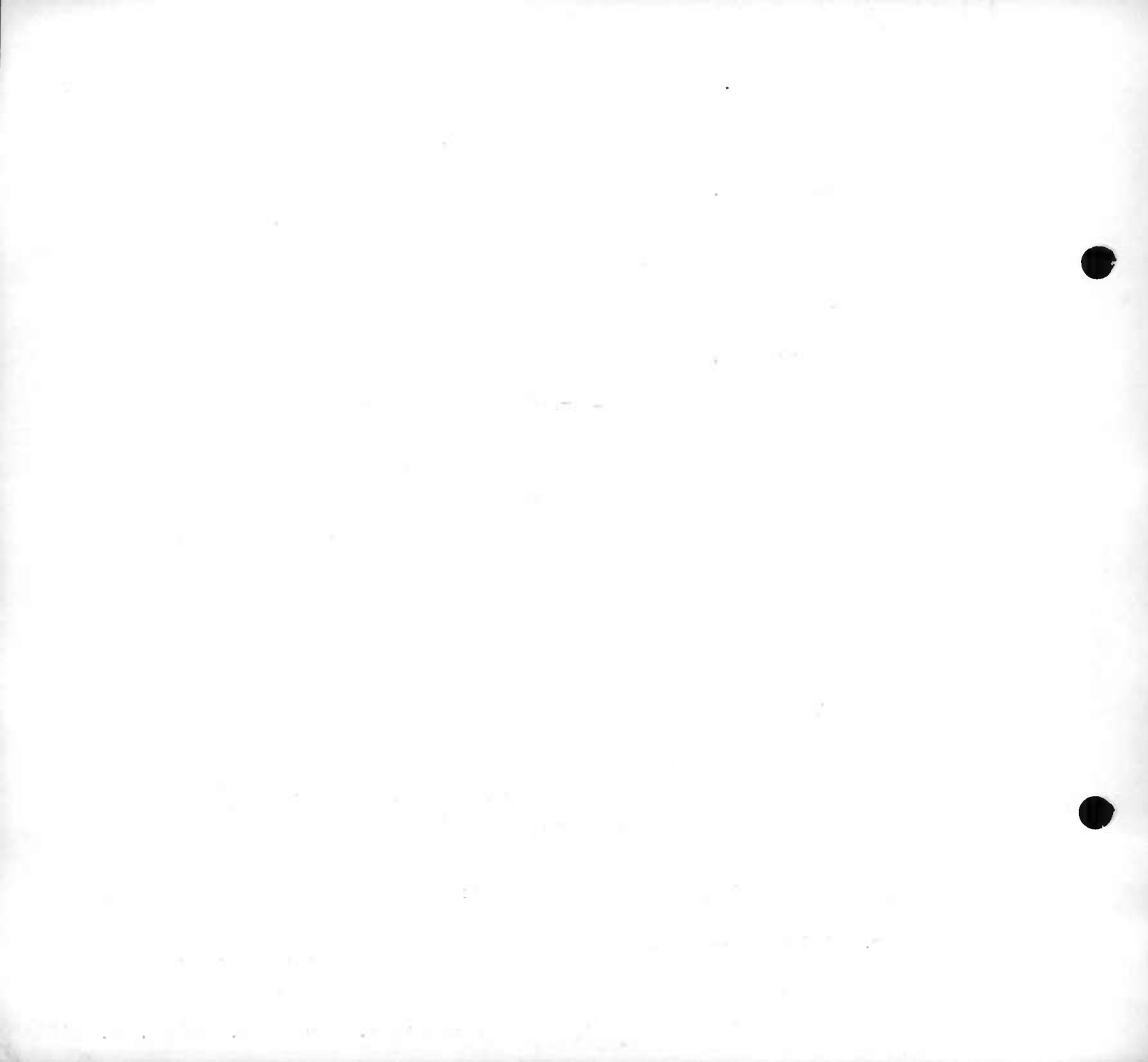
Q-362 71 3651		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3651	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) QUATTROCHI, ANTHONY LOUIS		2. DATE AND HOUR OF DEATH 4/6/71 7:35	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.		P. M.	
FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS OWNER		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		8. DATE OF BIRTH 8-14-19	
13. FATHER'S NAME LOUIS QUATTROCHI		14. MOTHER'S MAIDEN NAME GRACE COSTANZA (angelica)		9. AGE (In years last birthday) 51	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3/1/42 TO 2/7/46		16. SOCIAL SECURITY NO. 1-9-09-5487		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
17. INFORMANT V. A. HOSPITAL MEDICAL RECORDS		ADDRESS BALTIMORE, MD. 21218		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 50% BODY BURNS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/6/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SEEN GRAFTING FOR BODY BURNS		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2904 Erie Ave 53-00	
21D. TIME OF INJURY (Approx.) 2-19-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Heating Pad caused fire in bed.	
22. I certify that (1) (this hospital) attended the deceased from 3/22 19 71 to 4/6 19 71 that (2) (we) last saw the deceased alive on 4/6 19 71 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE Mark B. Orringer, M.D.		DEGREE		23B. DATE SIGNED 4/7/71	
23C. PHYSICIAN'S NAME (Type) MARK B. ORRINGER, M.D.		DEGREE		23D. ADDRESS VETERANS ADMINISTRATION HOSPITAL, 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/71		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Cemetery Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____
1. NAME OF DECEASED (Type or Print) MARIE L. KAHL		2. DATE AND HOUR OF DEATH April 9, 1971 9 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3010 Pelham Ave.		A. STATE Md. B. COUNTY 2633		
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/29/1896		9. AGE (In years last birthday) 75		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles G. Jacobs		
14. MOTHER'S MAIDEN NAME Sallie Stevenson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 217-09-0297		17. INFORMANT Miss Margaret Jacobs		
18. ADDRESS Same		19. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension Cardiovascular A.D.		(C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 15 1969 to 4-9 1971 that (I) (we) lost saw the deceased alive on 4-2-71 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE William L. Fearing				23B. DATE SIGNED 4-10-71
23C. PHYSICIAN'S NAME (Type) Dr. William Fearing				23D. ADDRESS 3025 Belair Rd., Balto. Md.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		
25B. NAME OF REGISTRAR E. J. Ruck		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md.		
25D. ADDRESS 21214				



BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 71 3653									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) David Halley					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 12 Year 71 Hour 2:30 a.m.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1505 E. Baltimore					3. DATE PRONOUNCED DEAD Month 4 Day 12 Year 71 Hour 2:30 a.m.				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 301									
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 8/8/02		10. AGE (In years lost birthday) 68		11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.		E. STREET AND NUMBER 1505 E. Balto. St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		14B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218-18-6970	
18. INFORMANT Jack P. Halley		ADDRESS 1307 Purnell Rd.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction with hemopericardium ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes - partial					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. INJURY OCCURRED partial		22H. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 4/12/71									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/71		24C. NAME of CEMETERY or CREMATORY Balto. Cem.		24D. LOCATION (City, town, or county) Balto. Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR Paul E. Chenoweth		25C. FUNERAL DIRECTOR Paul E. Chenoweth 3rd. 3617 Chestnut Ave.		ADDRESS			

Autumn

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

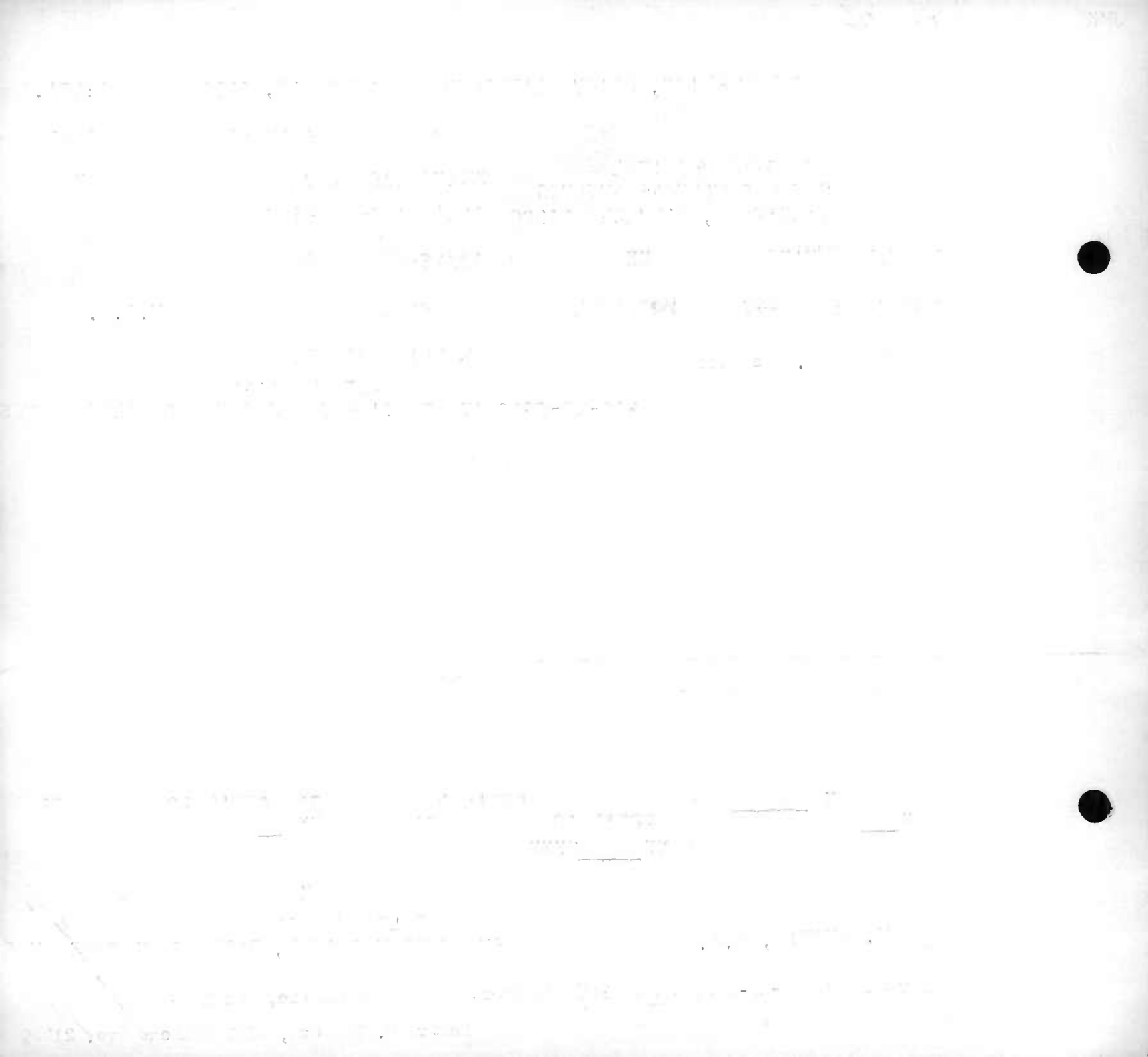
<div style="display: flex; justify-content: space-between;"> 7-600 71 3654 BALTIMORE CITY HEALTH DEPARTMENT X </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 71 3654 </div>			
1. NAME OF DECEASED (Type or Print) RYE GLENN GLENNIE FRYE		2. DATE AND HOUR OF DEATH APRIL 10 1971 7:40AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY Howard	
		C. CITY OR TOWN BALTIMORE ELKRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 6010 OLD WASHINGTON ROAD 21227	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/21/98
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER		10B. KIND OF BUSINESS OR INDUSTRY CATERING	9. AGE (In years last birthday) 72
13. FATHER'S NAME ROBERT LEE FRYE		11. BIRTHPLACE (State or foreign country) MARYLAND	
14. MOTHER'S MAIDEN NAME SARAH WATERS		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 232 10 3820	
		17. INFORMANT ADDRESS 0 ST AGNES HOSPITAL BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema	
ANTECEDENT CAUSES		(B) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atherosclerotic Cardiovascular Disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		OH Cerebro Vascular Accident	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 04/04/71 19 to 04/10/71 19 that (X) (we) last saw the deceased alive on 04/10/71 19 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED 04/10/71	
23C. PHYSICIAN'S NAME (Type) QUIROZ SALVADOR MD		23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-1971	
24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR	
		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BORCHERDING, DAISY ELIZABETH		APRIL 10, 1971 1:27A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND B. COUNTY BALTIMORE 21227	
5. SEX FEMALE		6. RACE WHITE		C. CITY OR TOWN ARBUTUS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/25/08		9. AGE (in years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME John W. Bennett		14. MOTHER'S MAIDEN NAME MOLLIE ROBERTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-5533		17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 174 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Metastatic Ca of breast. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from APRIL 4 19 71 to APRIL 10 19 71 that (X) (we) last saw the deceased alive on APRIL 10 19 71 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE M. Rustia		23B. DATE SIGNED 10 April 71		23C. PHYSICIAN'S NAME (Type) M. RUSTIA, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. NAME OF REGISTRAR Howard H. Hubbard		24F. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

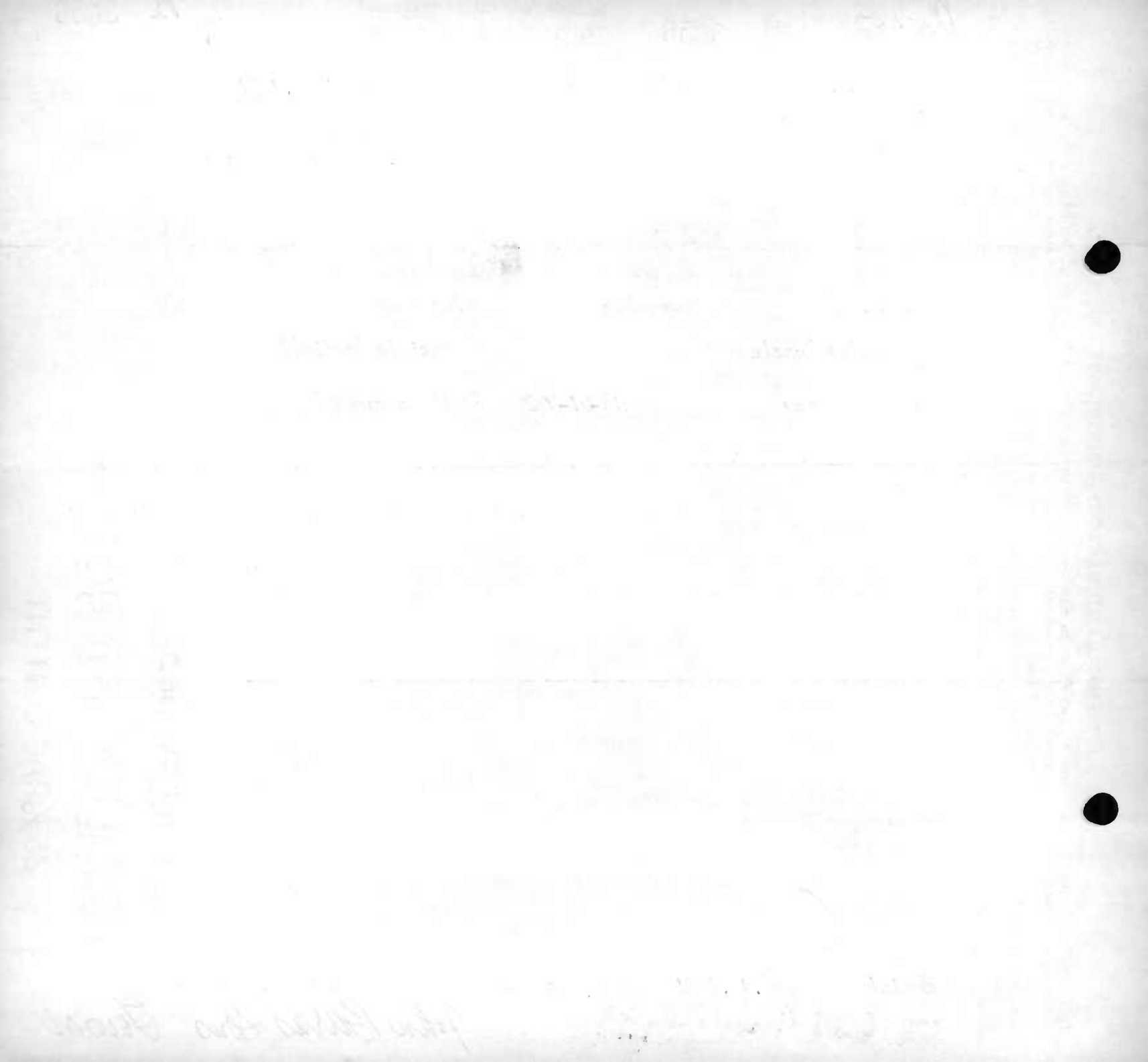
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
71 3656					71 3656					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
Webster Helen J					April 8, 1971					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
Md Gen Hosp FULL NAME OF HOSPITAL OR INSTITUTION 48					Md Baltimore A. STATE B. COUNTY 5300					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rogers Forge 21212					
D. STREET ADDRESS (If rural, give location) 1564plus Rd										
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
F		Cauc		M		2/16/18		53		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
wife			Homemaker			Maryland			USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME				
Charles Kurrle						Lucille Coefield				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No						None		214-01-9029		Family records
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						(A) Pulmonary embolism			1 wk	
ANTECEDENT CAUSES						(B) Metastatic Carcinoma Lung			4 mo	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C)				
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Jan 71				Ca. Lung				No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
<input type="checkbox"/>				<input type="checkbox"/>						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/5/71 19 to 4/8/71 19, that (I) (we) last saw the deceased alive on 4/8/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE								23B. DATE SIGNED		
James H. [Signature]								4/8/71		
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial			Apr. 12, 1971		Loudon Park Cemetery			Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR		
APR 14 1971				[Signature]				John [Signature]		
ADDRESS										
[Signature]										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 3657</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Bostice Ph. Per</u>				2. DATE AND HOUR OF DEATH <u>4-11-71</u> <u>8:00 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>335 Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1905 E. EAGLE ST.</u>			
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1912</u>	9. AGE (In years last birthday) <u>58</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Tredell, N.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Eccles, OSCAR</u>			14. MOTHER'S MAIDEN NAME <u>MAE TURNER</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>242077511HA</u>		17. INFORMANT <u>Marie Eccles</u>		
			ADDRESS <u>32-22 103 St. East Elmhurst</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11369</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Lactic acidosis</u> <u>2 days</u> <u>Post coronary artery surgery peripheral embolic phenomenon</u> <u>20 days</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>3-21-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pre infectious mononucleosis</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>			
21D. TIME OF INJURY (APPROX.) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>4-1-71</u> to <u>4-11-71</u> that (I) (we) last saw the deceased alive on <u>4-10-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Antonio Gonzalez-Reilla</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-11-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Antonio Gonzalez-Reilla M.D.</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-14-71</u>		24C. NAME of CEMETERY or CREMATORY <u>National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Randolph J. Collick 2431 E. Oliver St.</u>			

10

15-12-2

Pre infection

64

50

52

64

-1-

01 - 4

1. 2

55

44

15

3-11

15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3658</u>	
G-000 <u>71 3658</u>		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN GEE (JOHN KIM GEE)</u>		2. DATE AND HOUR OF DEATH <u>APRIL 9, 1971 8:50A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CA WREN HOME S HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>205 S. WOLFE</u>			
5. SEX <u>Male</u>	6. RACE <u>Chinese</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02/04/04</u>	9. AGE (in years last birthday) <u>67</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>City of Balto.</u>		11. BIRTHPLACE (State or foreign country) <u>CHINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>XXXXXXX GEE (first name unknown)</u>			
14. MOTHER'S MAIDEN NAME <u>(first name unknown) Lee</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>218-30-5179</u>		17. INFORMANT ADDRESS <u>MRS. PEARL GEE 205 S. Wolfe</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure</u> <u>COPD. Pulm. Tuberculosis(?)</u> <u>old CIA, Septicemia, Electrolyte Imbalance</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 10</u> 19 <u>71</u> to <u>April 9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rolando Mendoza</u>		23B. DATE SIGNED <u>4-9-71</u>		23C. PHYSICIAN'S NAME (Type or Print) <u>ROLANDO MENDOZA, M.D.</u>	
23D. ADDRESS <u>100 N. Broadway, Balto. MD 21231</u>		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/14/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION <u>Woodlawn, Balto. Co., Md.</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>Robt. E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO.</u>	
25D. ADDRESS <u>108 W. NORTH AV.</u>		25E. CITY <u>BALTIMORE</u>			

2000 1000 500 0



1000 500 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3659	
P 45671 3659		Baltimore City Health Department			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Zenada Palmer		4/10/71 8:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Md.		2612	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/24/96		9. AGE (In years lost birthday) 75		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Randell		14. MOTHER'S MAIDEN NAME Margaret Stewart	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 157-01-1544A		17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Maryland 21224	
18. 41241		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: - ? CVA - ? Asp. Pneumonia - ASCVD, Chronic or Syst. - Extensive blood sore			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (?) Myopathy (C) - chronic fibroid - Caris Teel - Periodontal disease - CVA, Probable Bacterial Pneumonia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-3 19 69 to 4-10 19 71 that (I) (we) last saw the deceased alive on 4/10/71 at 8:15 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. Seshachary MD		23B. DATE SIGNED 4/10/71		23C. PHYSICIAN'S NAME (Type) P. SESHACHARY MD	
23D. ADDRESS BCH. 4940 Eastern Avenue Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Balto. Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971	
25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sullivan Funeral Home - 1011 13th Ave			

1-3-69 Adm. No Previous

Address Available.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

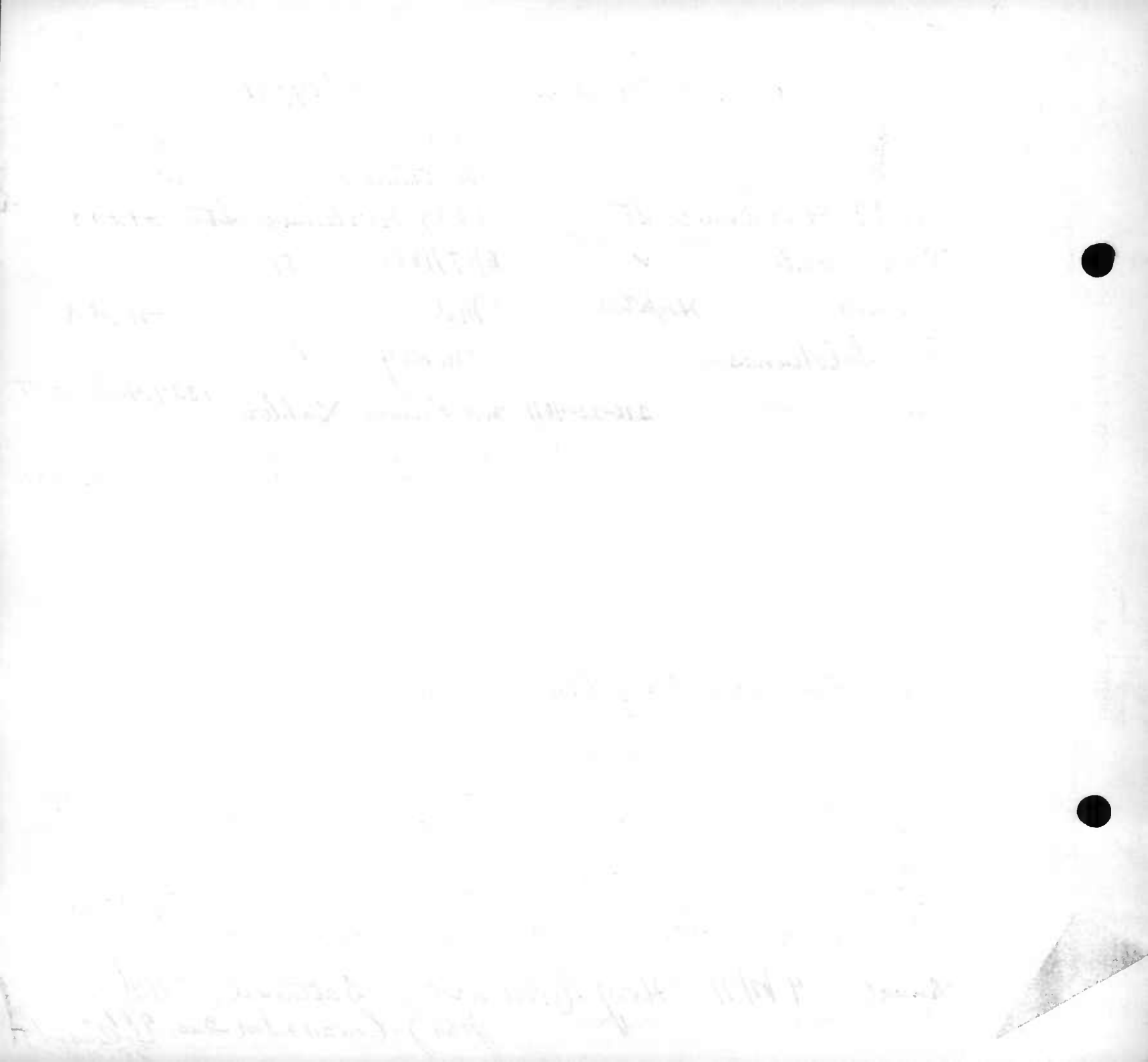
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3660	
B-510 71 3660 BIRTH NO. 1. NAME OF DECEASED (Type or Print) BUNIFF, William Charles		2. DATE AND HOUR OF DEATH 4-13-71 12:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2301 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 110 West Clements Street			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-15		9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME James Buniff		14. MOTHER'S MAIDEN NAME Emma Saunders			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes 9-17-43 to 12-13-45		16. SOCIAL SECURITY NO. 212-01-94-07		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
(A) IMMEDIATE CAUSE Hepatic coma DUE TO, OR AS A CONSEQUENCE OF: Hepatic cirrhosis with portal hypertension				years	
(B) DUE TO, OR AS A CONSEQUENCE OF: G. I. Bleeding				1 month	
(C) DUE TO, OR AS A CONSEQUENCE OF: Renal failure					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>March 1,</u> 19 <u>71</u> to <u>April 13,</u> 19 <u>71</u> and that (U) (we) lost saw the deceased alive on <u>April 13,</u> 19 <u>71</u> and that (N) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death.					
23A. SIGNATURE <i>C. L. Cromwell, M.D.</i> DEGREE				23B. DATE SIGNED 4/13/71	
23C. PHYSICIAN'S NAME (Type) C. L. CROMWELL, M.D. DEGREE				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/71		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem Garden	
24D. LOCATION Towson Balto Co Md		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971			
25B. NAME OF REGISTRAR <i>McCall F. H.</i>		25C. FUNERAL DIRECTOR ADDRESS 130 E. Fort Ave 21218			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3661	
BIRTH NO. H-100		71 3661		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Alice E. Stube			2. DATE AND HOUR OF DEATH 4/14/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md B. COUNTY 2102		
FULL NAME OF HOSPITAL OR INSTITUTION 00			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
1339 Herkimer St.			E. STREET AND NUMBER 1339 Herkimer St. 21223		
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1889	9. AGE (in years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Hospital		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? Salchunas			14. MOTHER'S MAIDEN NAME Mary ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 216-27-4681		
17. INFORMANT Mrs Emma Kahler			ADDRESS 1339 Herkimer St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 16211 I Cerebrovascular disease (A) IMMEDIATE CAUSE Left lung DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: 		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9-15-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of lung, left		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/20 19 53 to 4/14 19 71 that (I) (we) last saw the deceased alive on 4/14/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr MD				23B. DATE SIGNED 4/14/71	
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR MD				23D. ADDRESS 1227 WASH. BLVD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/17/71		Holy Redeemer Cem. Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR R. E. Taber, Md.		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc. 901 E. Baltimore St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-640 71 3662		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 3662	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John F. Oehrl		4/12/71 5:40P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.		A. STATE Maryland		B. COUNTY Anne Arundel	
		C. CITY OR TOWN Pasadena		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 8473 Meadow Lane		#21122 (Riviera Beach)	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-00	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired shipfitter		10B. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Oehrl		14. MOTHER'S MAIDEN NAME Carolyn Meiers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218.18.7170		17. INFORMANT Mrs. William Oehrl (son) Hospital Records	
				ADDRESS Timonium, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 5-7-70 1 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute PANCREATITIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Upper GI bleed (stress ulcer)				HOURS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10 April 19 71 to 12 April 19 71 that (I) (we) last saw the deceased alive on 12 April 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Benedict A. Termini		23B. DATE SIGNED 13 April 71		23C. PHYSICIAN'S NAME (Type) BENEDICT A. TERMINI	
23D. ADDRESS MERCY HOSPITAL, BALTO.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 16/71	
24C. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK		24D. LOCATION (City, town, or county) (State) Elkridge, RFD, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971	
25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR R. E. Taylor		25D. ADDRESS Singleton Funeral Home Glen Burnie, Maryland	

X

1. The first of the three

is

2. The second

3. The third

4. The fourth

5. The fifth

6. The sixth

A-635

71

3663

BALTIMORE CITY HEALTH DEPARTMENT

X

71

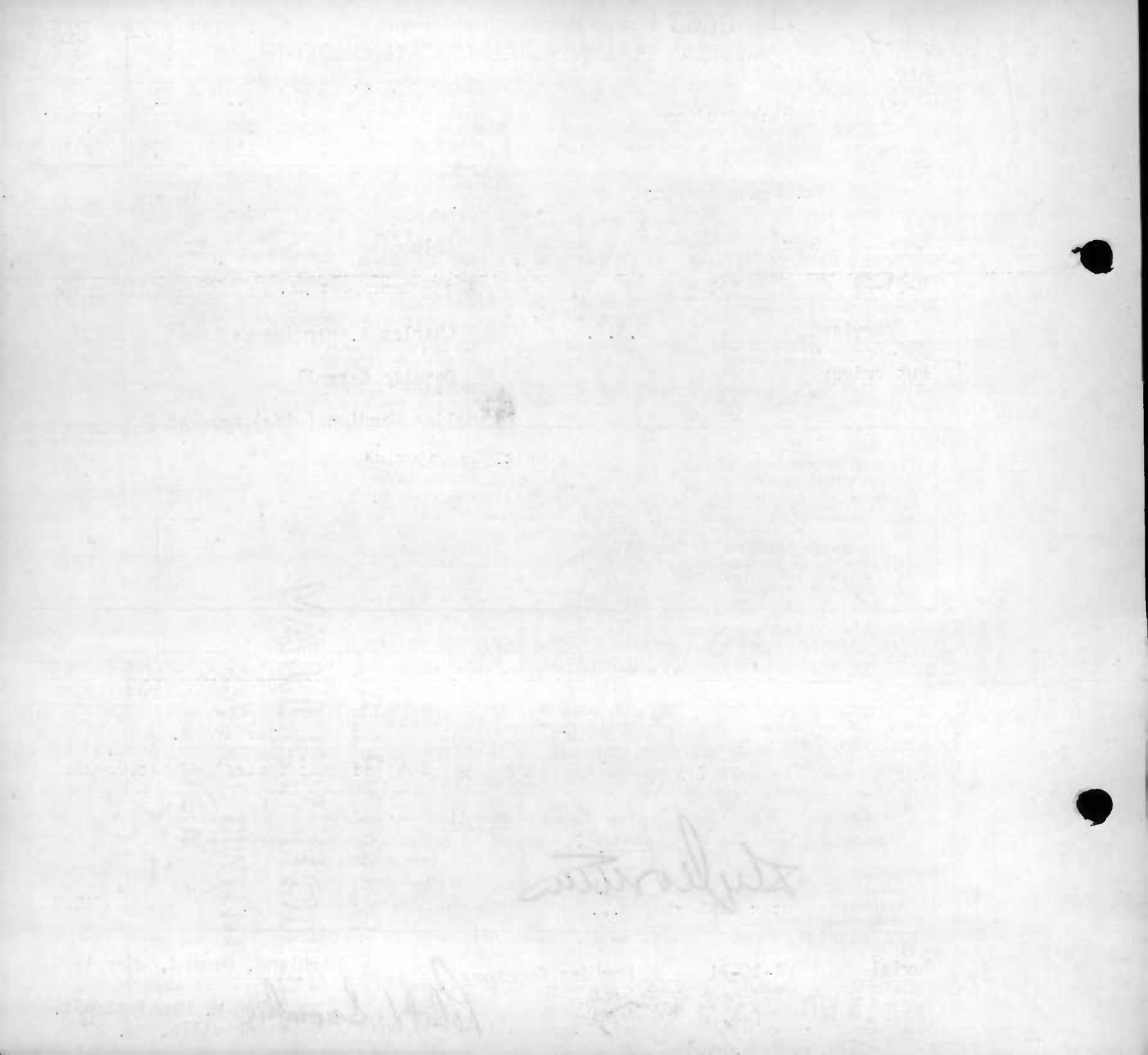
3663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Charles Harding				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 11 71 8:27 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 11 71 8:27 p.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Howard 6300							
6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Columbia	
9. DATE OF BIRTH 9-21-29		10. AGE (In years lost birthday) 41		11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 6015 Turnabout La.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles A. Harding		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		15. MOTHER'S MAIDEN NAME Cosette Carroll	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Madeline Harding (wife) same as 5		ADDRESS	
19. E8161.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 2				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ROAD			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Berger Rd. 6300				22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 4 11 71 7:59 p.m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subject lost control of motorcycle			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/12/71 EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-71		24C. NAME OF CEMETERY or CREMATORY Hopkins Cemetery		24D. LOCATION (City, town, or county) (State) Highland, Howard, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS 46 N. Washington St. Rockville, Md. 20850	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				X	
71 3664		CERTIFICATE OF DEATH		REG. NO. 71 3664	
Y-000		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
XXXXXXXXXXXXXXXXXXXX LOU-ZSE HOU YU		04.09.71 - 03.50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
38 University of Maryland Hospital, Balt.		Maryland		Frederick	
5. SEX		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. RACE		E. STREET AND NUMBER			
Yellow		1201 Fairview Ave. Frederick			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years)	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		06-23-1911		59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker		China June 23, 1911		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Unknown		Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		217-56-1870		Dr. Ching-Sung Yu	
				1201 Fairview Avenue Frederick, Maryland 21701	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
02-09-71				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on April 9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Gustavo Rios A. Rocha		April 9, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
GUSTAVO RIOS A. ROCHA		University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Cremation		4-13-71		Cedar Hill Crematorium	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 15 1971		R. E. Bailey, M.D.		Robert E. Bailey & Son	
				Frederick, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

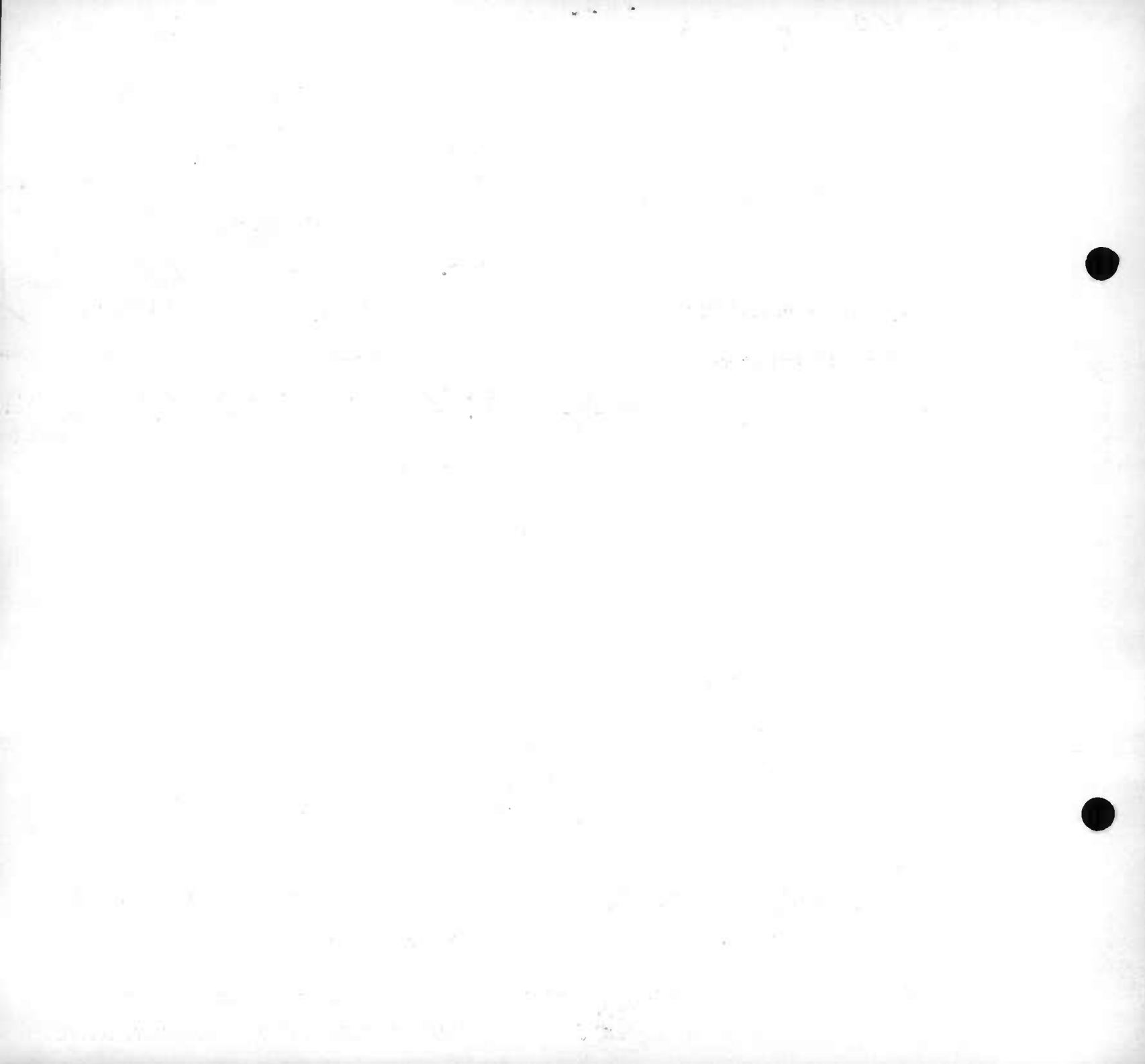
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3665	
1. NAME OF DECEASED (Type or Print) Catherine White		2. DATE AND HOUR OF DEATH 4/4/71 12⁴⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Owings Mills D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Hosp. 6600			
5. SEX F 6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1932 9. AGE (In years last birthday) 39 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Curtis White		14. MOTHER'S MAIDEN NAME Mary White			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. M.D. None		17. INFORMANT Hosp. chart ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arrested hydrocephalus & recent subdural hematoma					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rosewood State Hosp.	
21D. TIME OF INJURY (APPROX.) 1-15--71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell in cottage	
22. I certify that (I) (this hospital) attended the deceased from 3/20/71 19 71 to 4/4 19 71 that (I) (we) last saw the deceased alive on 4/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hubert T. Gurley				23B. DATE SIGNED 4/4/71	
23C. PHYSICIAN'S NAME (Type) Hubert T. Gurley		23D. ADDRESS Univ. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery	
24D. LOCATION (City, town, or county) (State) Owings Mills, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971 25B. NAME OF REGISTRAR J. E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Eline Funeral Home ADDRESS Reisterstown, Md.					

6/08 Sunnyside La
Oxen Hill, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. 71 3666				
1. NAME OF DECEASED (Type or Print) <u>WILLIAM LLOYD STURGIS</u>					2. DATE AND HOUR OF DEATH <u>4/9/71</u> <u>2:30</u> P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>WICOMICO</u> C. CITY OR TOWN <u>SALISBURY</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>407 E. VINE ST.</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3, 1919</u>	9. AGE (In years last birthday) <u>51</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housepainter</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lloyd William Sturgis</u>					14. MOTHER'S MAIDEN NAME <u>Nannie Adams</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-10-9614</u>		17. INFORMANT <u>Mrs. Dorothea S. Tilghman (Sister)</u> <u>Mrs. Julia Hosier, Salisbury, Md. (Sister)</u>			
18. <u>225-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>INTRACRANIAL SURGERY</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>4/1/71</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR</u>			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>4-9</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-26</u> 19 <u>71</u> to <u>4-9</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4-9</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>David M. Cook</u> DEGREE					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>4/9/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>David M. Cook</u> DEGREE					23D. ADDRESS <u>Baltimore, Maryland</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/13/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3667</u>	
B-200 <u>71 3667</u>		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Louise Buesche Bueche</u>		2. DATE AND HOUR OF DEATH <u>April 7, 1971</u> <u>2:40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore City</u> B. COUNTY <u>2733</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Harford Gardens Nursing Home</u>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4700 Harford Road</u>		<u>Elmora Ave</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/1879</u>	9. AGE (In years last birthday) <u>92</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frederick Buesche</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Haake</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-0154</u>		17. INFORMANT <u>Mrs Marie Miller</u>	
18. <u>4379</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral arteriosclerosis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Decubitus ulcer</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>April 7, 1971</u> , that (I) (we) last saw the deceased alive on <u>Feb 18, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald Jandorf</u> DEGREE				23B. DATE SIGNED <u>4-7-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u> DEGREE				23D. ADDRESS <u>7403 Harford Rd.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/10/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Immanuel</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>W. Deenman</u>		25D. ADDRESS <u>6067 Hay, Rd</u>			

4900

Coded to Hartford Rd.

Adm. 11 yrs. Ago.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 3668</u>	
C-200 71 3668		BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Cook, William R</u>		2. DATE AND HOUR OF DEATH <u>Apr. 11, 1971</u> <u>3:00</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>44 Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2452 Brentwood Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-05-08</u>	9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disability (Chapman) contractor</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>		
13. FATHER'S NAME <u>James Abraham Cook</u>			14. MOTHER'S MAIDEN NAME <u>Susie Fitzgerald</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>720-09-6039</u>		17. INFORMANT <u>Mrs. Lillian M. Cook</u>		ADDRESS <u>same</u>
18. <u>485X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 4</u> 19 <u>71</u> to <u>Apr. 11</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Apr. 11</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>John Ohe MD</u>				23B. DATE SIGNED <u>Apr. 11, 1971</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Tohru OHE MD</u>				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		24D. LOCATION (City, town, or county) (State) <u>Towson, Balt. Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>Ph. E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Mr. Chastan - 1701 McCall St.</u>			

Chief Engineer

520-61-6021

200

Received 4/17/71
from Mr. J. L. ...
for ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		71 3669		BALTIMORE CITY HEALTH DEPARTMENT		71 3669	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Noah Brown				2. DATE AND HOUR OF DEATH April 9, 1971 2:30 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland				C. CITY OR TOWN Baltimore, Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY Thinking Co.		8. DATE OF BIRTH 1-13-04	
13. FATHER'S NAME unk				14. MOTHER'S MAIDEN NAME unk		9. AGE (In years last birthday) 67	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 219-05-1861		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
17. INFORMANT Mrs. Alberta Catherine Brown				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 4-7-71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA ESOPHAGUS 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ND 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 4-1-71 to 4-9-71 that (I) (we) last saw the deceased alive on 4-9-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Dr. P. D. L. L. L. 23B. DATE SIGNED 4-9-71 23C. PHYSICIAN'S NAME (Type) Dr. P. D. L. L. L. 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/10/71 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary 24D. LOCATION Anne Arundel Co. Md. 25A. DATE REC'D BY HEALTH DEPT. APR 15 1971 25B. NAME OF REGISTRAR R. E. E. E. 25C. FUNERAL DIRECTOR Wm. Chestnut - 1701 M. E. E. E. ADDRESS							

2000 ...
Baltimore, Maryland

730 ...
Baltimore, Md.

x

Male Negro

1-13-20

U. S. ...

Virginia

219-02-1861 Mrs. Albert ...

4-9-21

2-1-21

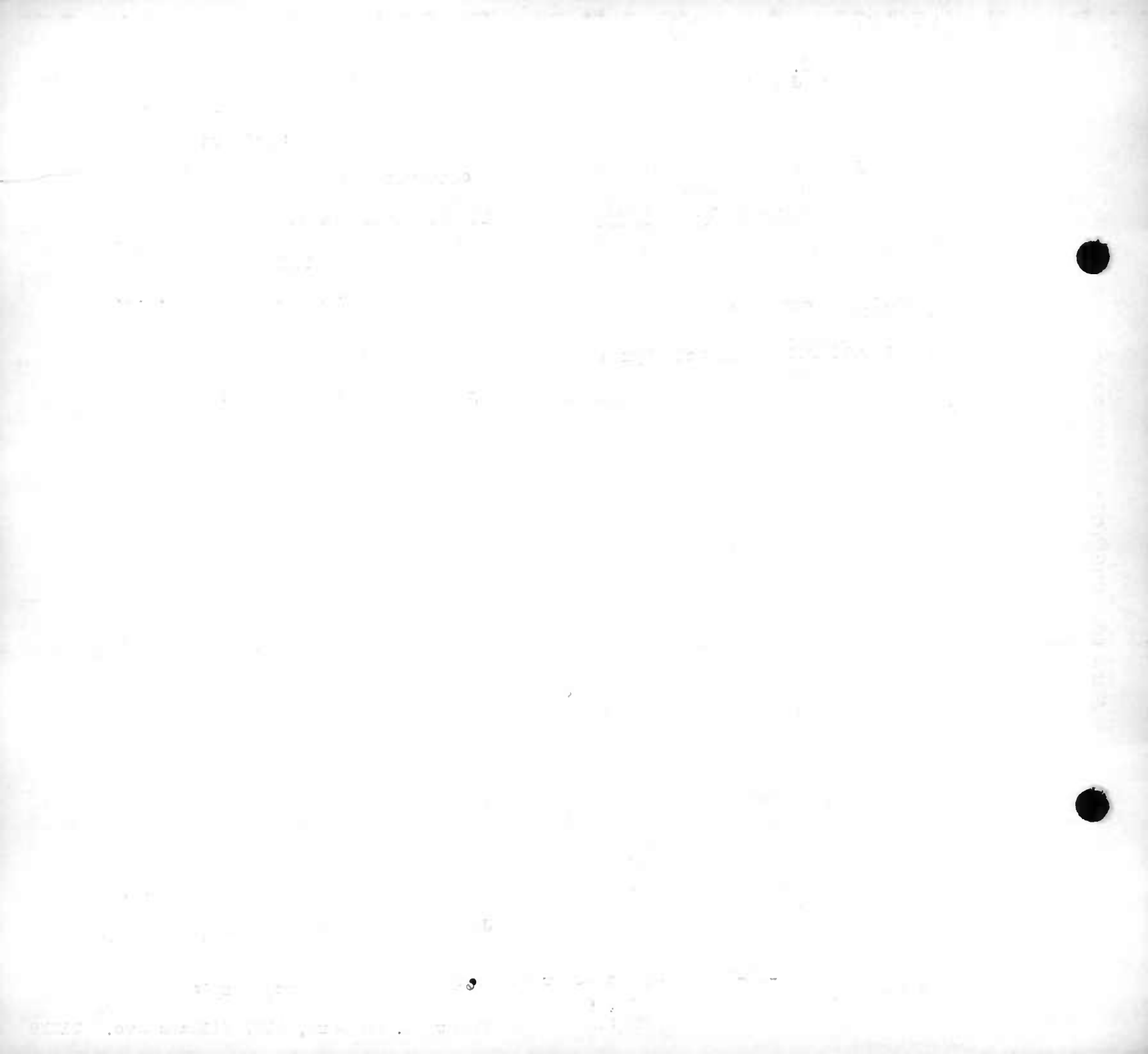
2-8-21

4-9-21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BIRTH NO. J-536 71 3670</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 3670</p>	
<p>1. NAME OF DECEASED (Type or Print) Mary Jendrek</p>				<p>2. DATE AND HOUR OF DEATH April 11, 1971 4:20 P. M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION 91</p>		<p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>A. STATE Maryland</p>		<p>B. COUNTY Baltimore</p>	
<p>Jenkins Memorial Hospital</p>		<p>1000 Caton Avenue</p>		<p>C. CITY OR TOWN Catonsville</p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>Baltimore, Maryland 21229</p>				<p>E. STREET AND NUMBER 11 Seminole Avenue</p>			
<p>5. SEX Female</p>		<p>6. RACE W.</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 4/24/1880</p>	
				<p>9. AGE (In years last birthday) XX 90</p>		<p>10. UNDER 1 Yr. Months: Days: Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Baltimore, Md.</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>							
<p>13. FATHER'S NAME Michael Byrnes</p>				<p>14. MOTHER'S MAIDEN NAME Alice Smith</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown</p>				<p>16. SOCIAL SECURITY NO. 213-54-2257</p>		<p>17. INFORMANT Jenkins Memorial</p>	
				<p>ADDRESS 1000 Caton Ave</p>		<p>Baltimore, Md. 21129</p>	
<p>18. CAUSE OF DEATH</p>							
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)</p>				<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrhythmia minutes.</p>			
<p>ANTECEDENT CAUSES</p>				<p>(B) Atherosclerotic Heart Disease 10 yrs</p>			
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(C) Renal failure - chronic 1 year</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Renal failure - chronic</p>							
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (A) (this hospital) attended the deceased from Dec. 8 19 71 to April 11 19 71 that (A) (we) last saw the deceased alive on 4/11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE J. Raymond Gladue</p>				<p>23B. DATE SIGNED 4/12/71</p>			
<p>23C. PHYSICIAN'S NAME (Type) J. R. Gladue</p>				<p>23D. ADDRESS Jenkins Memorial Hospital</p>		<p>1000 Caton Ave. Baltimore, Md. 21229</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE 4-14-71</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 15 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>		<p>25C. FUNERAL DIRECTOR Howard H. Hubbard</p>		<p>ADDRESS 4107 Wilkens Ave. 21229</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3671	
K-520 BIRTH NO.		71 3671		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KINES, JOHN GOTTLIEB		APRIL 10 1971 9:40AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		A. STATE MARYLAND		B. COUNTY Anne Arundel 5200	
C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 626 MARGATE DRIVE 21061					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/03/89	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME GEORGE KINES		14. MOTHER'S MAIDEN NAME MARY L. KINES MARY L. MULLIGAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 05 6563		17. INFORMANT Mrs. Bernadette Puls, 1020 REEDS AVE. ST AGNES HOSPITAL BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema Congestive heart failure ASCVD.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 03/27/71 19 to 04/10/71 19 that (X) (we) last saw the deceased alive on 04/10/71 19 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 4/10/71		23C. PHYSICIAN'S NAME (Type) JOSE APTER MD	
23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229		23E. DEGREE DEGREE		23F. DEGREE DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-1971		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME of REGISTRAR Howard H. Hubbard, 4107 Wilkens Ave. 21229		24F. ADDRESS ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25C. FUNERAL DIRECTOR ADDRESS	

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

FUNERAL DIRECTOR: IMPORTANT

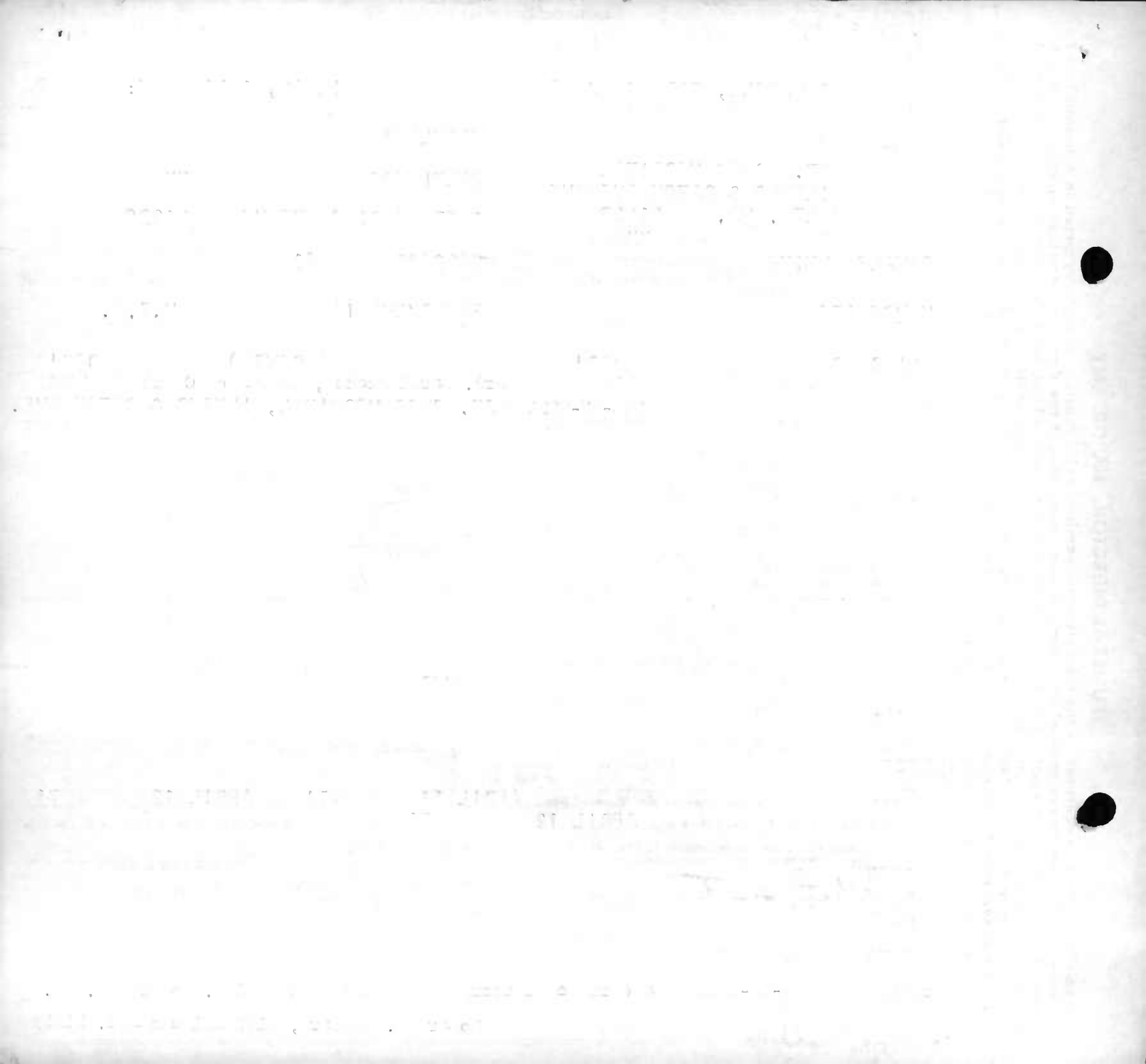
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346 71 3672				BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 3672	
1. NAME OF DECEASED (Type or Print) <u>HERBERT N. BOTELER</u>				2. DATE AND HOUR OF DEATH <u>4-12-71</u> <u>3:55 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTH CHARLES GEN. HOSP.</u> <u>49</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN <u>ARBUTUS</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>4742 WESTLAND BLVD. 21227</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-12</u>		9. AGE (In years last birthday) <u>58</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HERBERT E. BOTELER</u>				14. MOTHER'S MAIDEN NAME <u>M. EDNA MILLER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mildred A. Boteler, 4742 Westland Blvd.</u>			
						ADDRESS <u>21227</u>			
18. <u>162.1 I</u>				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u>				<u>Weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>month</u>	
				(C) <u>Generalized Metastases</u>					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3-16-71</u> to <u>4-12-71</u> that (I) (we) last saw the deceased alive on <u>4-12-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Jon G. O'Leary M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-12-71</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-16-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>				25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
CAMPBELL, BARBARA JANE		APRIL 12, 1971 5:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO., MD. 21229		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1907 DEERING AVENUE 21230	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/23/09
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 61
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELI CARR		14. MOTHER'S MAIDEN NAME (BREWER)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-42-2231	
17. INFORMANT Mrs. Carol States, 1406 Avon Court		18. ADDRESS 21227 ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
19. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 11</u> 19 <u>71</u> to <u>APRIL 12</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>APRIL 12</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ching-Hui Tsai, M.D.</u>		23B. DATE SIGNED 4/12/71	
23C. PHYSICIAN'S NAME (Type) <u>Ching-Hui Tsai, M.D.</u>		23D. ADDRESS <u>St Agnes Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-1971	
24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR <u>Robert J. ...</u>	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

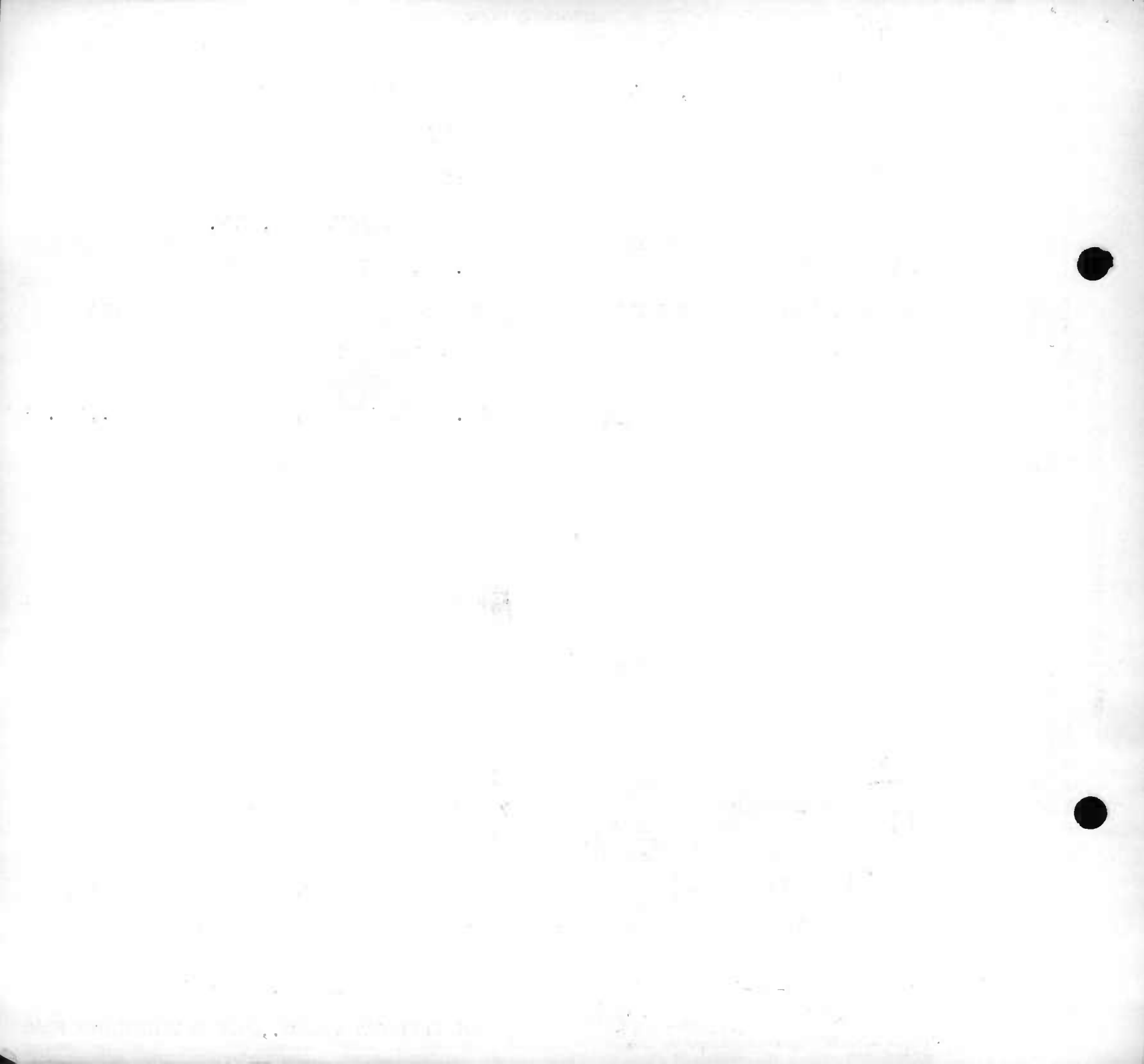
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3674	
S-526 71 3674 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHENKER, IDA.		2. DATE AND HOUR OF DEATH April 10, 1971 6.35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY 2730		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTO.			C. CITY OR TOWN BALTIMORE.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3221 CLARKS LA. 21215. APT. A		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/98.	9. AGE (In years last birthday) 73.	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PHILIP COHEN			
14. MOTHER'S MAIDEN NAME LEAH ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. BENJAMIN SCHENKER, 3321 CLARKS, LANE, APT. A			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Primary in the Bowel					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Atherosclerotic Cardiovascular Disease.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/1 1971 to 4/10 1971 that (I) (we) last saw the deceased alive on 4/10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Petsyas. M.P.				23B. DATE SIGNED 4/10/71.	
23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSYAS M.D.		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-12-71	24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Robert E. Feltz, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

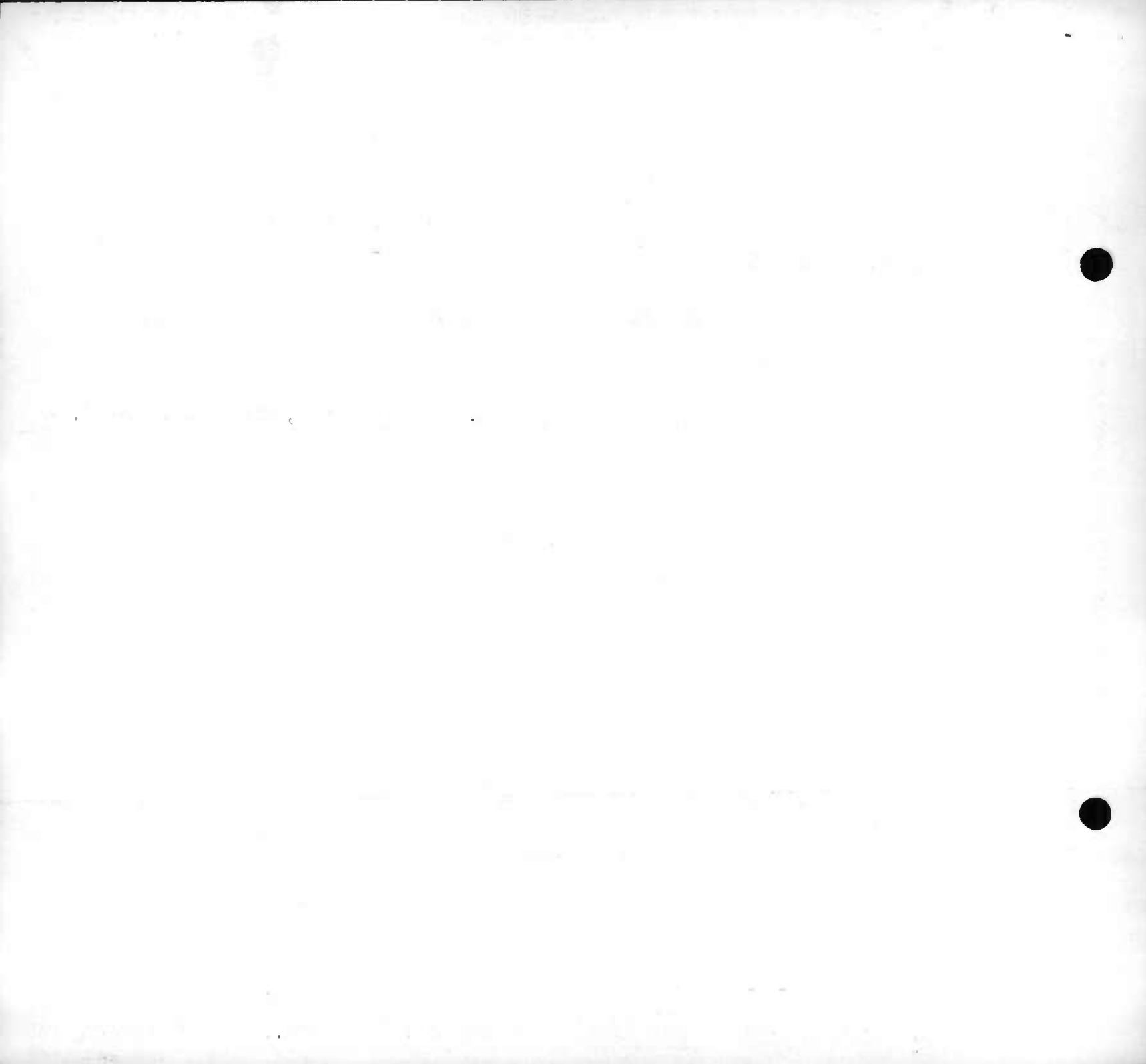
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3675	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) ADELMAN, ABRAHAM		2. DATE AND HOUR OF DEATH 4/13/71 8.50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 2740 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3102 BANCROFT ROAD, APT. A			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 26, 1897	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY PAINTER		11. BIRTHPLACE (State or foreign country) POLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME USHER ADELMAN		14. MOTHER'S MAIDEN NAME GITTEL ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. NORMA ADELMAN, 3102 BANCROFT RD., APT. A	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE Cardiogenic shock. DUE TO, OR AS A CONSEQUENCE OF: most probably due to MI. (B) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: disease (C) </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/10/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/13/71 to 4/13/71 19 71 that (I) (we) last saw the deceased alive on 4/13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ali M. Safa				23B. DATE SIGNED 4/13/71	
23C. PHYSICIAN'S NAME (Type) ALI M. SAFA, M.D.				23D. ADDRESS Sinai Hosp. of Balto.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-14-71		24C. NAME of CEMETERY or CREMATORY RUDOMER VEREIN	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971			
25B. NAME OF REGISTRAR John E. Sabin, Jr.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 3676	
G-635 71 3676		BIRTH NO.		71 3676		71 3676	
1. NAME OF DECEASED (Type or Print) GORDON, Evelyn				2. DATE AND HOUR OF DEATH 4/13/71 1245 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINDI HOSPITAL OF BALTIMORE INC.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 8216 STREAMWOOD DRIVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/30/40	9. AGE (in years last birthday) 30	10. Under 1 Yr. 11. Under 24 Hrs. 12. Under 24 Hrs. 13. Under 24 Hrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BOLIVIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EGON MICHAEL				14. MOTHER'S MAIDEN NAME CARMILA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. STANLEY GORDON, 8216 STREAMWOOD DR. #9			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CANCEROUS CACHEXIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMATOSIS CA of DESCENDING COLON				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/4/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 28 1971 to APRIL 13 1971 that (I) (we) last saw the deceased alive on 4/12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Alberto Cola M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/13/71	
23C. PHYSICIAN'S NAME (Type) ALBERTO COLA M.D.				23D. ADDRESS 2543 C Steele Rd. BALTIMORE Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-14-71		24C. NAME of CEMETERY or CREMATORY BETH JACOB		24D. LOCATION (City, town, or county) (State) FINKSBURG, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Albert C. Bailey		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 3677		X		71-3677	
BIRTH NO.		71 3677		CERTIFICATE OF DEATH		REG. NO. 71-3677	
1. NAME OF DECEASED (Type or Print) <u>Smith, Charles Murray</u>				2. DATE AND HOUR OF DEATH <u>4/13/71</u> <u>4:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>USPHS Hospital</u> <u>3100 Wyman Park Dr. Balto. Md. 21211</u>				A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balto. Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>Cauc</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>6/14/11</u>		9. AGE (In years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman - Ret.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Charles A. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ryan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217 07 7819</u>		17. INFORMANT <u>Records - USPHS Hosp.</u>	
18. <u>427.2 I</u> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Cardiorespiratory arrest</u>		<u>30 min.</u>	
ANTECEDENT CAUSES				(B) <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Advanced pulmonary fibrosis</u>						<u>years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that <u>(this hospital)</u> attended the deceased from <u>4/9</u> 19 <u>71</u> to <u>4/13</u> 19 <u>71</u> and that <u>(this hospital)</u> last saw the deceased alive on <u>4/13</u> 19 <u>71</u> and that <u>(this hospital)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael V. Jew, M.D.</u>				23B. DATE SIGNED <u>4/13/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael V. Jew, M.D.</u>	
23D. ADDRESS <u>USPHS Hosp. - Balto. Md. 21211</u>				23E. DEGREE <u>MD</u>		23F. DEGREE <u>MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4/17/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>C. F. EVANS & SON</u>		25D. ADDRESS <u>8802 Harford Rd.</u>	

~~SECRET~~

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-160 71 3678		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3678	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HUBER, Ruth M.		2. DATE AND HOUR OF DEATH 04-12-71 2:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21223 2005			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 416 S. PULASKI STREET			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09-30-14	9. AGE (in years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MILTON ***** Corbin		14. MOTHER'S MAIDEN NAME Katherine Grimes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 800-02-2846		17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CVA		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Hypertensive cardiovascular disease		6 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Diabetes mellitus		years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 11 1971 to April 12 1971 that (I) (we) lost saw the deceased alive on April 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Young Jai Lee M.D.		23B. DATE SIGNED April 12-71		23C. PHYSICIAN'S NAME (Type) YOUNG JAI LEE M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/71		24C. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery	
24D. LOCATION Westminster, Carroll Co., Md.		24E. DATE REC'D BY HEALTH DEPT. APR 15 1971		24F. NAME OF REGISTRAR. Robert E. Taber, M.D.	
24G. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker		24H. ADDRESS Streets 21223			

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

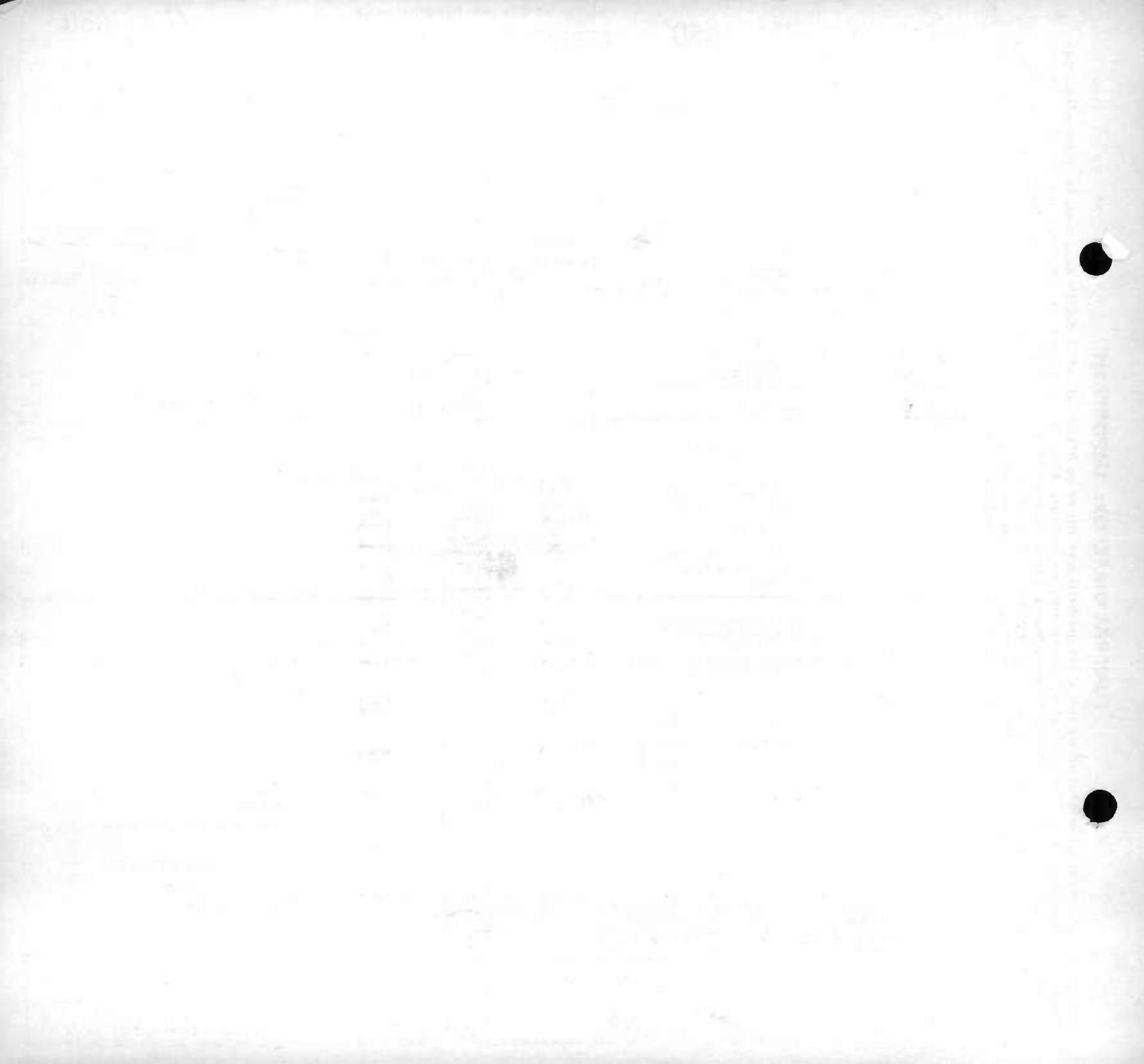
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3679	
8-423		71 3679	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SLEIGHT, LEE		2. DATE AND HOUR OF DEATH 4-10-71 4 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital		A. STATE MD B. COUNTY 1	
		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 813 Gorsuch Ave	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-98
		9. AGE (in years last birthday) 72	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Sleight		14. MOTHER'S MAIDEN NAME Anna May Griswold	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO -		16. SOCIAL SECURITY NO. 212-32-4445	
17. INFORMANT Mr Mrs Newell		ADDRESS 913 Gorsuch Ave	
18. 430X1 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus - massive		(A) IMMEDIATE CAUSE Left Ventricular Fibrillation	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction		(B) Due to, or as a consequence of:	
		(C) ASCD -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Exaggerated obesity, Diabetes Mellitus - Renal Failure, Years			
19A. DATE OF OPERATION 3-26-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Torn Tendon	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-24-1971 to 4-10-1971 that (I) (we) last saw the deceased alive on 4-10-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gustavo Hinososa		23B. DATE SIGNED 4-10-71	
23C. PHYSICIAN'S NAME (Type) GUSTAVO HINOSOSA		23D. ADDRESS MD. General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/15/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR C. F. Evans & Son		ADDRESS 8802 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
S-530 71 3680		71 3680		71 3680		71 3680	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Edward V Smith</u>				4/9/1971 6:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
THE Johns Hopkins Hospital				MD		A.A.	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				504 MELVIN AVE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. CITIZEN OF WHAT COUNTRY?
M	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	02-26-26	45			USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
LINE MAN				ANNAPOLIS, Md			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
C+P Telephone				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN Henry Smith				LOUIE AMANDA Weedon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				219-16-0081			
17. INFORMANT				ADDRESS			
Marry H. Smith -				ANNAPOLIS, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				18hrs			
ANTECEDENT CAUSES				3 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Hypertension, Diabetes			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4-8 1971 to 4-9 1971 that (I) lost saw the deceased alive on 4-9 1961 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Trexler M. Topping MD						4/9/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
TREXLER M. TOPPING				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-12-71		Hillcrest Cemetery		Annapolis, Md AnCo	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 15 1971		Robert E. Taylor, MD		Hardesty, Funeral Home		Annapolis Md	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3681		REG. NO. 71 3681	
BIRTH NO. B-250		71 3681		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS HELEN BIZON				2. DATE AND HOUR OF DEATH 4.14.71 3.20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1530 Lancaster St. 21231			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.8.1908		9. AGE (In years last birthday) 62 yrs	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Bochniak				14. MOTHER'S MAIDEN NAME Karolina Rog			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-4126		17. INFORMANT ADDRESS Frank Bizon 1530 Lancaster St (31)			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ca Right breast with multiple metastasis with Hepatosplenomegaly with Anemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
19A. DATE OF OPERATION 4.20.66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Breast Right		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4.14.71 19 to 4.14.71 19 that (I) (we) last saw the deceased alive on 4.14.71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Vasant Datta M.D.				23B. DATE SIGNED 4.14.71		23C. PHYSICIAN'S NAME (Type) VASANT DATTA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/17/71		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. APR 15 1971			
25B. NAME OF FUNERAL DIRECTOR George A. Weber				25C. FUNERAL DIRECTOR ADDRESS 705 South Ann Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-162 71 3682		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3682	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Maude Ethel Capers		2. DATE AND HOUR OF DEATH 4-14-1971 2:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1505		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland		E. STREET AND NUMBER 3322 Leighton Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1898	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ? Cuffy		14. MOTHER'S MAIDEN NAME Lucy ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-1592A		17. INFORMANT Lillian Johnson ADDRESS 3322 Leighton Avenue	
18. 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypertensive Cardiovascular Disease 1 year.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pontine Thrombosis (B) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: Septic Peritonitis (C) Several hours 2 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-13-1971 to 4-14-1971 that (I) (we) last saw the deceased alive on 4-14-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Shafi		23B. DATE SIGNED 4-14-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) M. JAVAHIR SHAFI		23D. ADDRESS PROVIDENT HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-16-1971	24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE	

Provisional Hospital, Inc.
7500 Liberty Heights Avenue
Baltimore, Maryland

3000 Lehigh Avenue

Lehigh Valley

Lehigh Valley

512-32-1292 William Johnson

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3683

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HAROLD COMEGYS

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

4

14

1971

2:50 a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1608

6. SEX

male

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

APRIL 20-1908

10. AGE (In years

lost by day)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

793 Grantley St.

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

GEORGE COMEGYS

14A. USUAL OCCUPATION (Give kind of work

done during most of working life, even if retired)

Ret Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Balto City Sewer Dept

15. MOTHER'S MAIDEN NAME

Mary

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL

SECURITY NO.

18. INFORMANT

HELEN M. COMEGYS 793 GRANTLEY ST

ADDRESS

412.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive & arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/14/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/17/71

24C. NAME of CEMETERY or CREMATORY

ARBUS MON PK

24D. LOCATION (City, town, or county)

ARBUS - BALTO MD 21227

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1971

25B. NAME OF REGISTRAR

E. Faber, M.D.

25C. FUNERAL DIRECTOR

Marshall P. Hays 638 N. Gilmor St

ADDRESS

1931

17

1931

17

1931

17

1931

17

1931

17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3684</u>	
P-620 71 3684				CERTIFICATE OF DEATH	
BIRTH NO. <u>P-620</u>		1. NAME OF DECEASED (Type or Print) <u>PARKS, GILBERT E.</u>		2. DATE AND HOUR OF DEATH <u>4/14/1971</u> <u>5:15 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>NO.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Beltan Hl Hsg. Home John St Md 21217</u>		
5. SEX <u>Male</u>	6. RACE <u>black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/1885</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. BARTENDER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>Sylvanus Boll</u>			14. MOTHER'S MAIDEN NAME <u>F. H. A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-3385A</u>		17. INFORMANT <u>Cassio Boll 7 N. Vincent St</u>	
18. <u>481X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/13/1971</u> to <u>4/14/1971</u> that (I) (we) last saw the deceased alive on <u>4/14/1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mohamed S. Al-Ibrahim M.D. C.B.B.</u>				23B. DATE SIGNED <u>4/14/1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. S. AL-IBRAHIM M.D. C.B.B.</u>				23D. ADDRESS <u>md. Gen. Hospital.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/20/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR <u>Marshall Hays 658 N. Gwyn St</u>	

49.71 adm. 1718 W. Franklin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3685</u>	
BIRTH NO. <u>71 3685</u>					
1. NAME OF DECEASED (Type or Print) <u>E. Mildred Gunzleman</u>		2. DATE AND HOUR OF DEATH <u>4/9/71</u> <u>7:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital Inc.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2608</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3803 E. Lombard St. #21224</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/95</u>	9. AGE (in years last birthday) <u>75</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John Raither</u>		14. MOTHER'S MAIDEN NAME <u>Emma Rosnick</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 34 9980</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0 none</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u>					
(B) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Chronic Heart Failure</u>					
MEDICAL CERTIFICATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>3/16</u> 19 <u>71</u> to <u>4/9</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>4/9/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Shawki N. Malek</u>		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/9/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SHAWKI N. MALEK</u>		23D. ADDRESS <u>Mercy Hospital 301 St. Paul Street #02</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/12/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cem.</u>	
24D. LOCATION <u>Balto Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph J. Zourenko</u>	
		ADDRESS <u>263 S. Conkey St.</u>			



A 352

71 3686

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3686

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN ADAMS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

4

10

1971

3 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

2608

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5/10/20

10. AGE (In years
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3703 Clairmount St.

11. BIRTHPLACE (State or foreign country)

Balto, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Adams

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

14B. KIND OF BUSINESS OR INDUSTRY

Church Home Hosp UNK

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

U.S. Coast Guard

17. SOCIAL
SECURITY NO.

218-07-9111

18. INFORMANT

Mrs Mary Adams

ADDRESS

same

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/11/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/14/71

24C. NAME of CEMETERY or CREMATORY

Zion Evang. Lutheran Cem

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1971

25B. NAME OF REGISTRAR

Robert E. Jaber, M.D.

25C. FUNERAL DIRECTOR

Joseph N. Ziemann 263 S. Conkling St.

ADDRESS

Clermont Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 3687

BIRTH NO. 11-216 71 3687

1. NAME OF DECEASED
(Type or Print)

MCPHERSON, MRS. SARAH

2. DATE AND HOUR OF DEATH

4-14-71

12:35

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Keswick Home for Incurables of

Balto., City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

209 Chancery Road

5. SEX

F.

6. RACE

W.

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11-17-1889

9. AGE (In years
last birthday)

81

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Glasgow, Scotland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Melville Christie

14. MOTHER'S MAIDEN NAME

Katherine Goodfellow

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL
SECURITY NO.

151-09-0019

17. INFORMANT

ADDRESS

KESWICK FILES 700 w. 40th St.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Arteriosclerotic CVD

years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from August 1970 to 14 April 1971,
that (1) (we) last saw the deceased alive on 14 April 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harold P. Biehl MD

Attending ☒
Phys.Med. ☐
DirectorStaff ☐
Phys.

23B. DATE SIGNED

14 April 71

23C. PHYSICIAN'S
NAME (Type)

Dr. Harold P. Biehl

23D. ADDRESS

Keswick Home

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

4-16-71

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore,

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1971

25B. NAME OF REGISTRAR

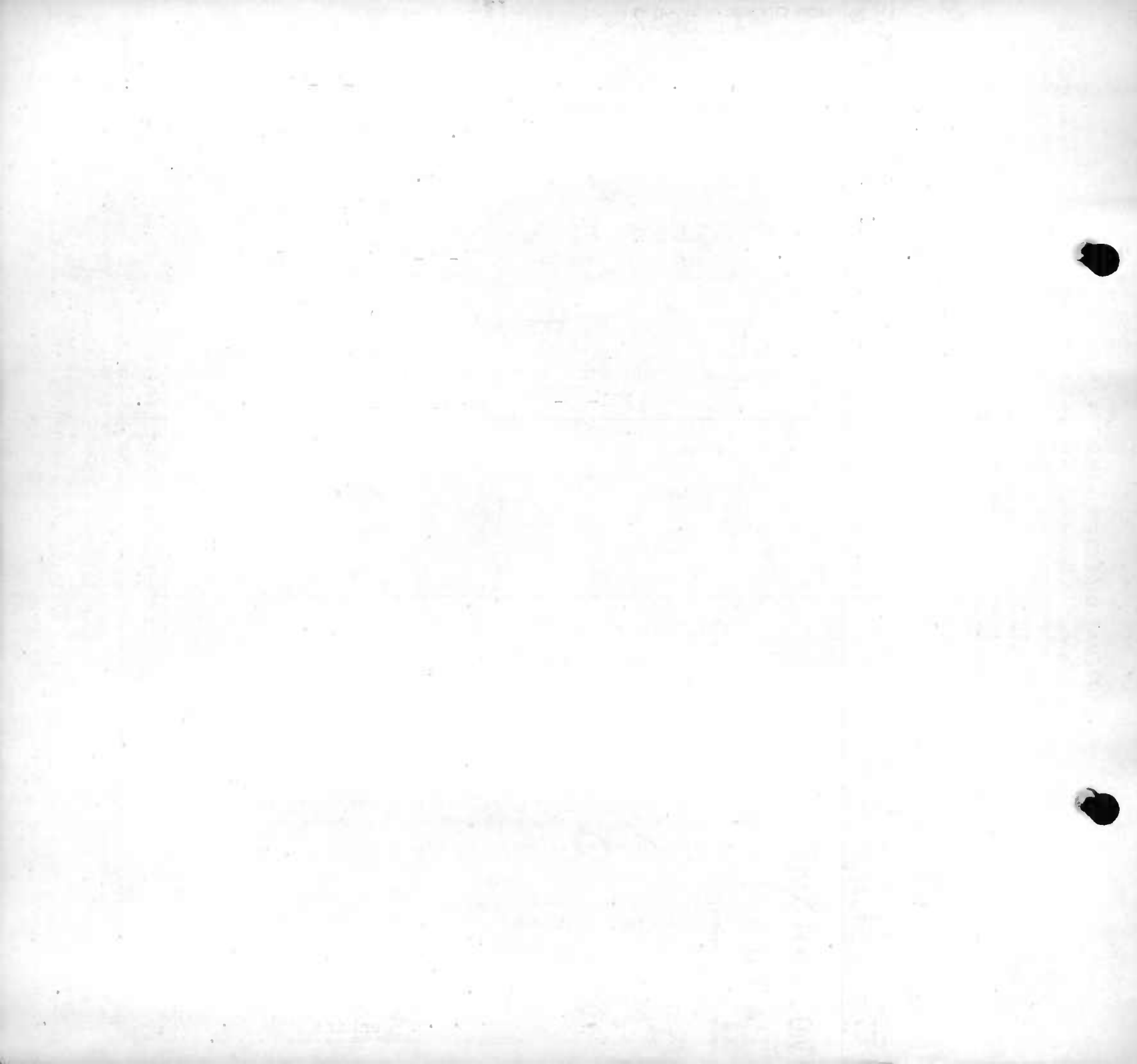
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins Sons Co. 4905 York Rd.

ADDRESS

Baltimore, Md. 21212



FUNERAL DIRECTOR: IMPORTANT

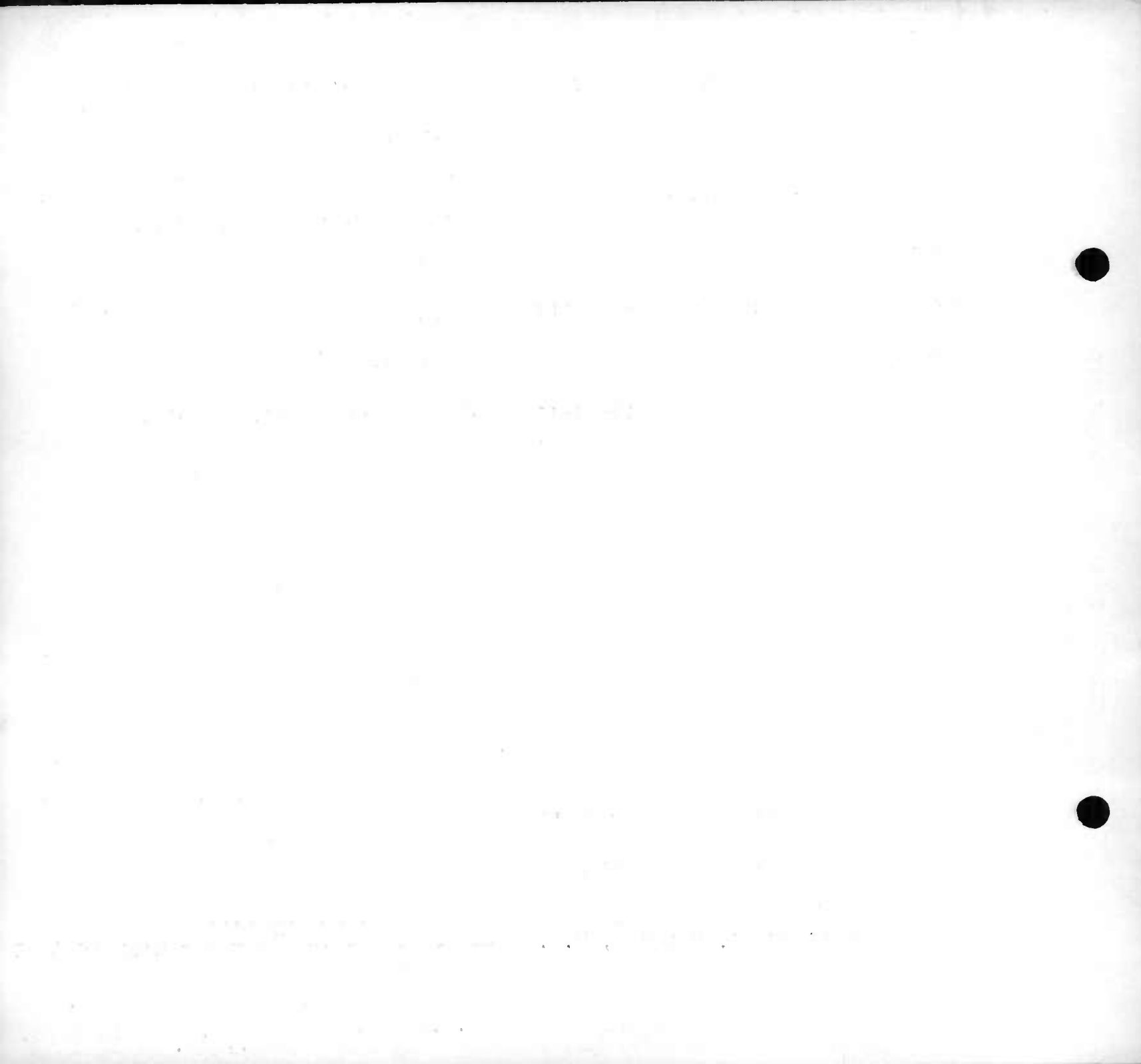
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3688	
BIRTH NO. R-326 71 3688				2. DATE AND HOUR OF DEATH 4-14-71 8:30 P. M.	
1. NAME OF DECEASED (Type or Print) Kent M. Redgrave Sr.				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4-2-1882 9. AGE (In years last birthday) 89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME Lancelot W. Redgrave				14. MOTHER'S MAIDEN NAME Catherine Hutchinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I II		16. SOCIAL SECURITY NO. 152 22 2570 A		17. INFORMANT John C. Sudak ADDRESS N. J. Cape May	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Congestive heart failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arterio sclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several months several years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION n		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-15 19 71 to 4-14 19 71 that (I) (we) last saw the deceased alive on 4-7 19 71 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 4.15.71	
23C. PHYSICIAN'S NAME (Type) Dr. E. E. Cook				23D. ADDRESS M.D. 11 McKim Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 4-15-71		24C. NAME OF CEMETERY OR CREMATORY Cold Spring	
24D. LOCATION (City, town, or county) (State) Cold Spring, N. J.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971 25B. NAME OF REGISTRAR J. E. Talley, R.D.			
25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Balto., Md. 21212					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-300 71 3689		CERTIFICATE OF DEATH		71 3689	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH	
HADAWAY, ERNEST RANDOLPH, SR.		40 ST AGNES HOSPITAL		APRIL 13, 1971 12:39 P.M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN	
40 ST AGNES HOSPITAL		MARYLAND		BALTIMORE	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
RETIRED-ACCOUNTANT		STRAYER COLLEGE		11-29-95	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
HARRY HADAWAY		IDA (KNADLER)		75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
NO		212-01-1186		U S A	
17. INFORMANT		18. CAUSE OF DEATH		17. ADDRESS	
ST AGNES HOSP RECORDS-BALTO, MD.		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NO		NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
MARCH 29		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		MARCH 29	
22. I certify that (I) (this hospital) attended the deceased from		23A. SIGNATURE		23B. DATE SIGNED	
that (I) (we) last saw the deceased alive on		Perfecto C. Valarao		4-13-71	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
APRIL 13 19 71		PERFECTO C. VALARAO, M.D.		BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/16/71		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 15 1971		J. E. Taber, M.D.		H.W. Jenkins & Sons Co.	
24D. LOCATION (City, town, or county) (State)		24E. ADDRESS		24F. ADDRESS	
Baltimore Md.		ST AGNES HOSPITAL CATON & WILKENS AVES		4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3690</u>	
BIRTH NO. <u>6-610</u>		71 3690		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Margaret G. Greve		2. DATE AND HOUR OF DEATH April 13, 1971 <u>2:45 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> Long Green Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6007 Clearspring Road	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-1909	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Western Electric		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Sidney Carter Gibson		14. MOTHER'S MAIDEN NAME Lelia Ethel Britts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-4300		17. INFORMANT Mr. Donald White 3206 Birchmere Drive	
18. <u>41231</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Due to, or as a consequence of: <u>Basilar artery stenosis</u>		4 mos	
ANTECEDENT CAUSES		(B) <u>Arteriosclerotic Heart Disease</u> Due to, or as a consequence of:		2 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>18 December</u> 19 <u>70</u> to <u>13 April</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>13 April</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John W. Barnaby</u>		23B. DATE SIGNED <u>15 Apr 71</u>		23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-1971		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Parkville,		24E. STATE Md.		24F. ADDRESS 1652 E. Belvedere Avenue	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR <u>John W. Jenkins</u>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.,	
25D. ADDRESS 4905 York Road Balto.,		25E. ADDRESS Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 3691	
BIRTH NO. W-425 71 3691		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MR. WILKINS JOHN W.		2. DATE AND HOUR OF DEATH April 13 th , 1971, at 2:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, BALTIMORE, MARYLAND 21224		A. STATE MARYLAND		B. COUNTY 1205	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1619 E. LATROBE ST. 21202			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-88	9. AGE (In years last birthday) 82	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Winnie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-0385		17. INFORMANT Fannie Wilkins 4940 Eastern Avenue, Baltimore, Maryland 21224 St.	
18. 1971 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA - DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Metastatic Anaplastic Carcinoma DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Dementia -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 24, 1971 to April 13 th , 1971 that (I) (we) lost saw the deceased alive on April 13 th , 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Prakash G. Sane				23B. DATE SIGNED April 13, 1971	
23C. PHYSICIAN'S NAME (Type) Dr. PRAKASH G. SANE				23D. ADDRESS BALTIMORE CITY HOSPITALS, BALTIMORE 4940 Eastern Avenue Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-71		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION Laurel, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971			
25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR 1735 Harford Avenue Marshall W. Jones, Jr.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. D-624				71 3692		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 3692	
1. NAME OF DECEASED (Type or Print) CHARLES J. DREXLER SR.				2. DATE AND HOUR OF DEATH 4-13-71 10:10 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2534							
FULL NAME OF HOSPITAL OR INSTITUTION 43		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSP		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 3609 4th ST.											
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-14	9. AGE (In years last birthday) 57	11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driller			10B. KIND OF BUSINESS OR INDUSTRY Bethlem Steel Co.								
13. FATHER'S NAME JAMES (DEC)				14. MOTHER'S MAIDEN NAME ALVIA (DEC)							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none			16. SOCIAL SECURITY NO. 215-05-5910		17. INFORMANT Thomas R. Drexler			ADDRESS 3609 4th St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma with widespread metastasis to the liver and gastro-intestinal tract				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) [] [] [] []		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from March 23 1964 to April 12 1971 and that (I) (we) last saw the deceased alive on April 13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Joseph M. Presbitero</i>				23B. DATE SIGNED 4-13-71							
23C. PHYSICIAN'S NAME (Type) JOSE M. PRESBITERO M.D.				23D. ADDRESS South Balto. Gen. Hospital Balto. Md							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/71		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Old. Frederick Rd. Balto Md					
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971				25B. NAME OF REGISTRAR Robert E. Gaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Krause Funeral Home 12163 Charles St.					

A 211

1000 1000 1000

1000 1000

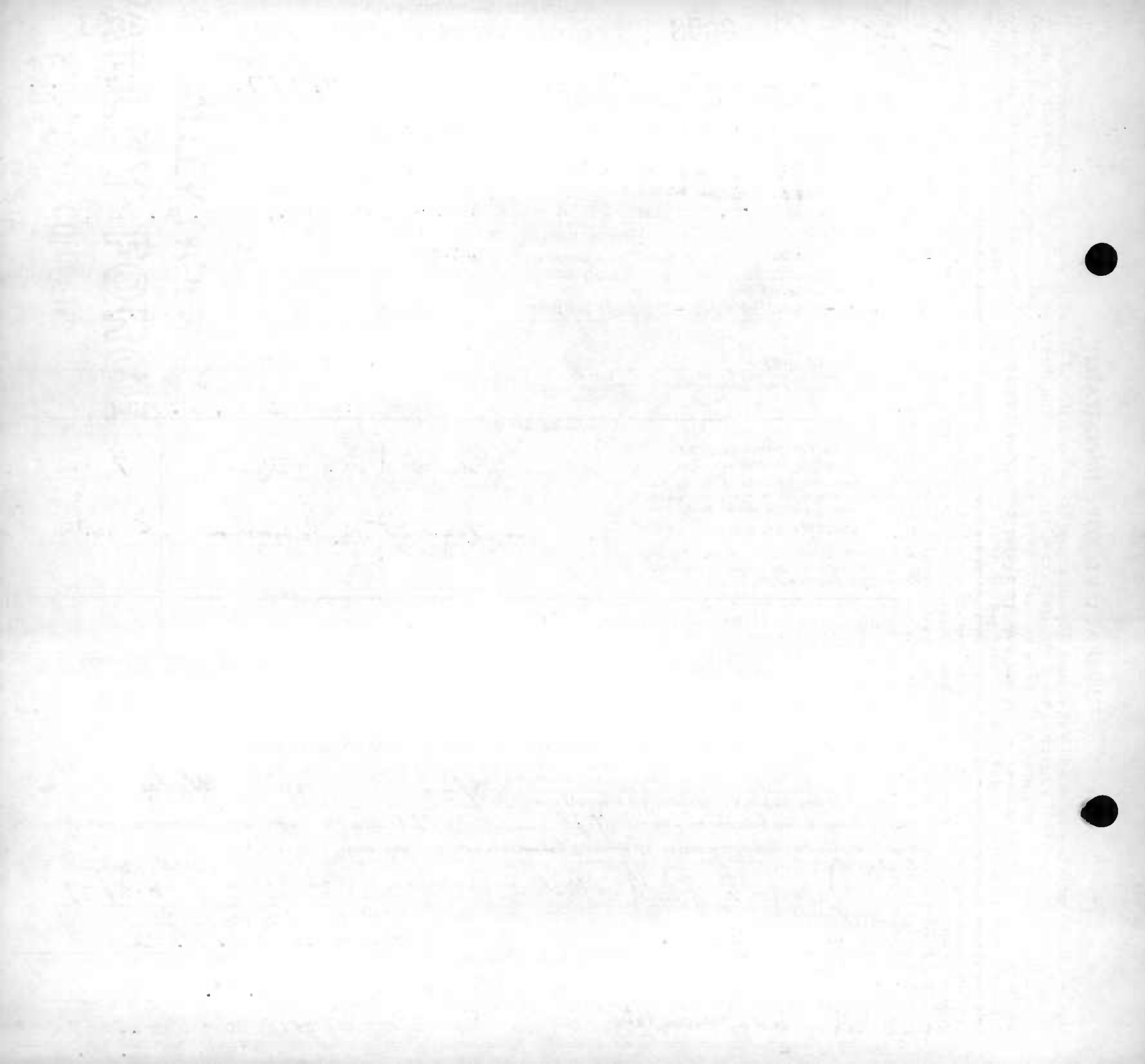
1000 1000

1000 1000

1000 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. G-652 71 3693				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3693	
1. NAME OF DECEASED (Type or Print) GRANGER ELLEN				2. DATE AND HOUR OF DEATH 4/8/71 10:10 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland		B. COUNTY 2653	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3906 Southclaire Rd., Balto. Md. 21213			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-7-16	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Assenbly Line-Black & Decker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edward Ray			
14. MOTHER'S MAIDEN NAME Johanna Naevy				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT BCH Records: Baltimore, Md. 21224			
18. I 1729 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE cerebral metastasis DUE TO, OR AS A CONSEQUENCE OF: 2 yrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/22 19 71 to 4/8/71 19 71 , that (2) (we) last saw the deceased alive on 4/8 19 71 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Roll M.D.				23B. DATE SIGNED 4/8/71			
23C. PHYSICIAN'S NAME (Type) Joseph Roll, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/12/71		24C. NAME of CEMETERY or CREMATORY Govans Presbyterian Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc., 3331 Brehm Lane, Balto. Md. 21213	



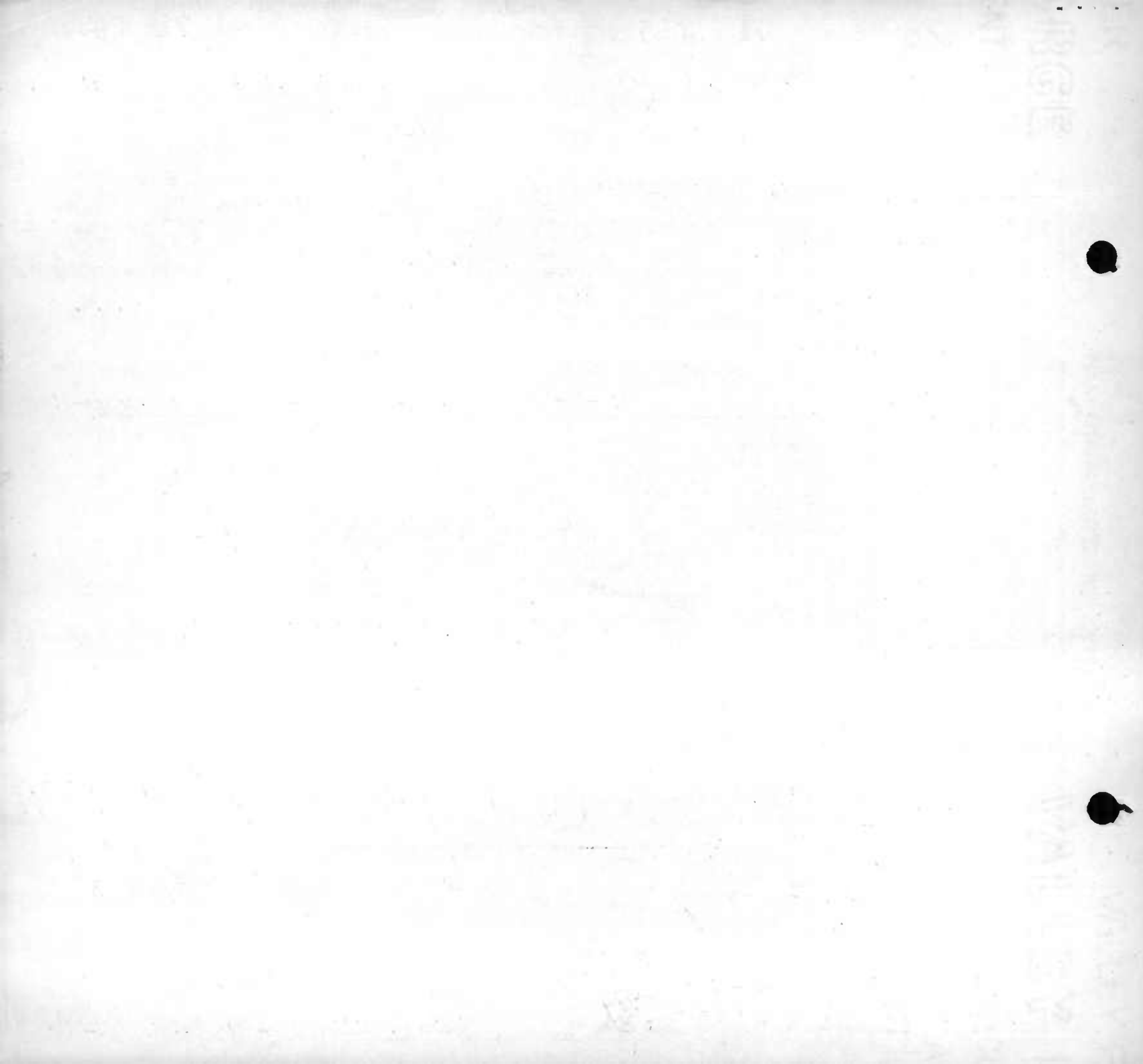
BIRTH NO.		71 3694		BALTIMORE CITY HEALTH DEPARTMENT		71 3694	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) Miller (IRVING) IRVIN GERMAN JR.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 10 1971 7:09a M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2643							
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9/10/06		10. AGE (In years last birthday) 64		E. STREET AND NUMBER 4120 Ardley Ave.			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Irving M. German			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Amelia Krodel			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		17. SOCIAL SECURITY NO. 220-09-0304		18. INFORMANT ADDRESS Helen G. Brown, sister, above			
19. CAUSE OF DEATH 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 4/10/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/71		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimineck Funeral Home Inc. 3331 Brehms Lane			

WALTER W. BLOOM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

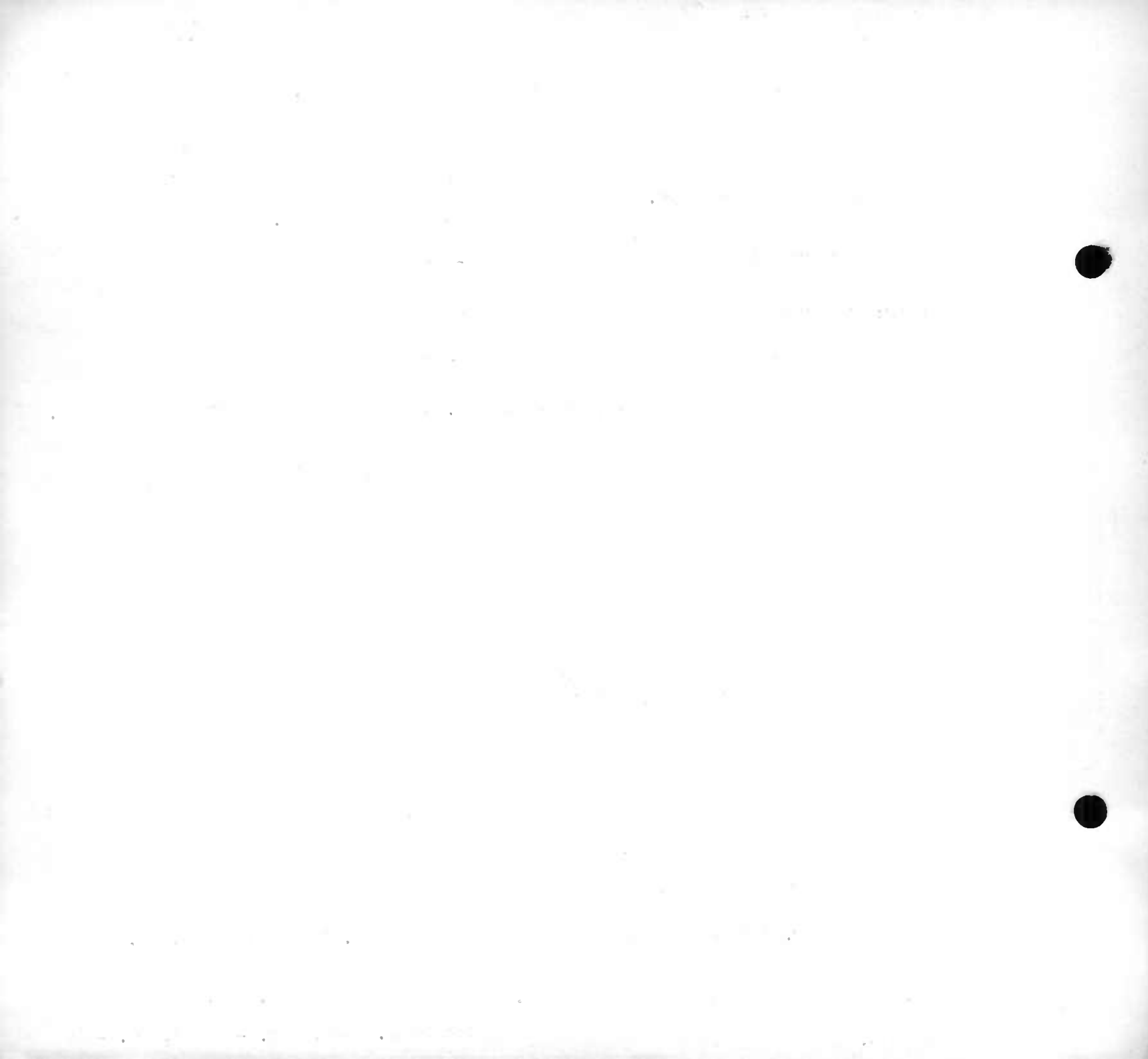
BIRTH NO. <i>T-526</i>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>71 3695</i>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
<i>Andrew E. Thumser</i>				<i>April 8, 1971 7:10 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <i>Maryland</i>		B. COUNTY <i>804</i>	
<i>90 House in the Pines-Belair</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>2237 Prentiss Place</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 17, 1885</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Entertainer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Gwynn Oak Park</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. City</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Clara Thumser</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-14-1377</i>		17. INFORMANT ADDRESS <i>Mrs. Lois Kirsch - 5020 Edgar Terrace-21214</i>			
18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i> (B) <i>Generalized Arteriosclerotic Vascular Disease</i> years (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Emphysema; Chronic; Probable Prosthetic CP</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/7/1971</i> to <i>4/8/1971</i> , that (I) (we) last saw the deceased alive on <i>4/7/1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Arthur D. Bready</i>				23B. DATE SIGNED <i>4/12/71</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>4-12-71</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd.-21206</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

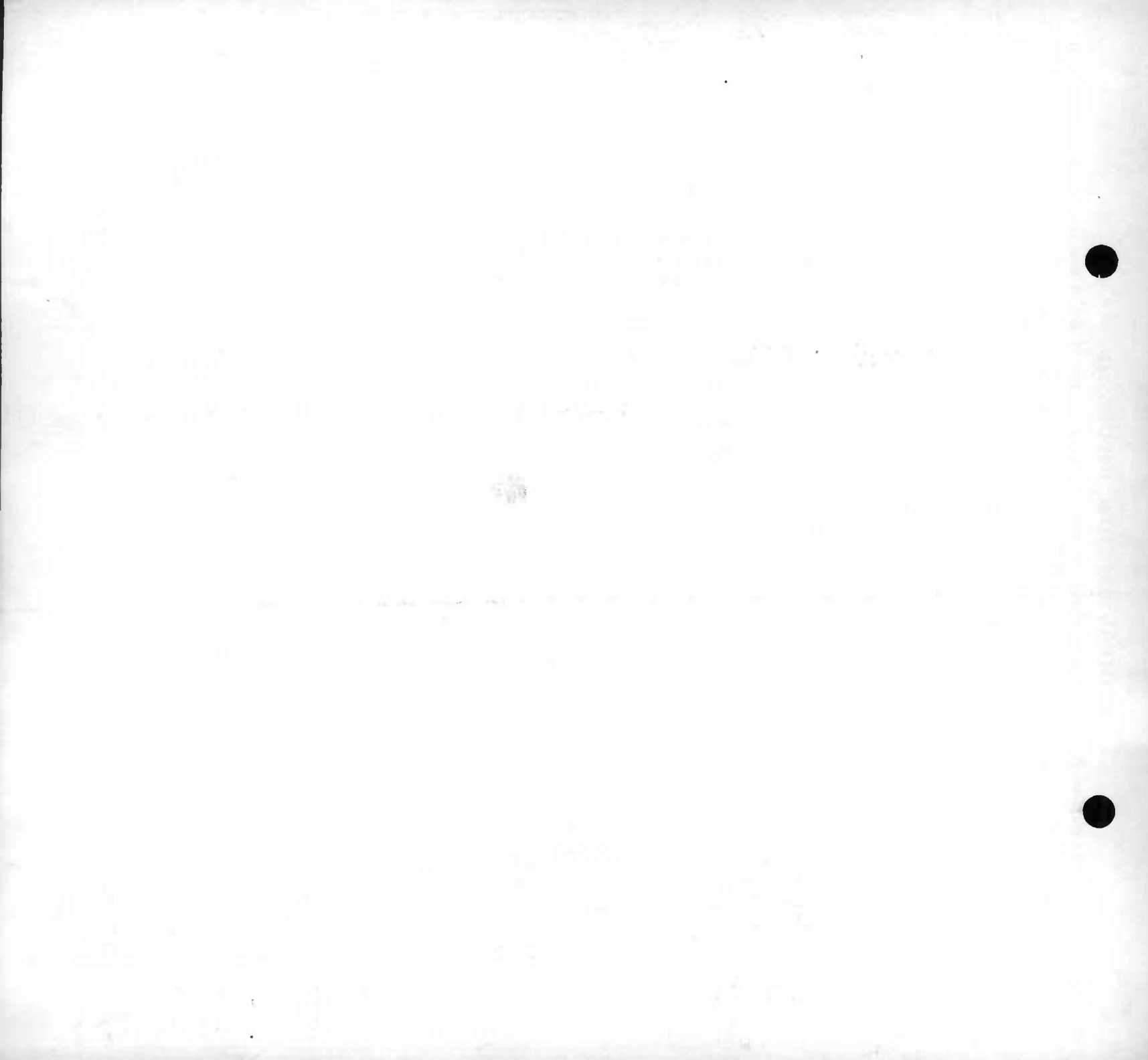
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3696	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) RUPERT HESS		2. DATE AND HOUR OF DEATH April 14, 1971 14:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3103 Westfield Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2745 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3103 Westfield Ave.			
5. SEX male	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-91	9. AGE (in years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baker: retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Hess			
14. MOTHER'S MAIDEN NAME Margaret Schneider		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-10-6737		17. INFORMANT ADDRESS Mrs. Elizabeth White, 3103 Westfield Ave.			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Cancer of rectum DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 08/10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of rectum		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/31 1970 to 3/11 1971 that (I) (we) last saw the deceased alive on 7/11 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William E. Gilmore M.D.				23B. DATE SIGNED 4/14/71	
23C. PHYSICIAN'S NAME (Type) Dr. William Gilmore				23D. ADDRESS 108 E. 33rd St, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md. XX		25A. DATE REC'D BY HEALTH DEPT. APR 15 1971			
25B. NAME OF REGISTRAR Robert E. Garber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. - Balto, Md. - 14			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>G-552 71 3697 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: right;">REG. NO. 71 3697</p>			
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) DOROTHY R. GIAMMANCO</p>		<p>2. DATE AND HOUR OF DEATH 4/13/71 1:50 p.m.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2765</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 4403 Colman Gardens Drive</p>	
<p>5. SEX F</p>	<p>6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>	<p>8. DATE OF BIRTH 11/29/23 9. AGE (in years last birthday) 47</p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A</p>	
<p>13. FATHER'S NAME Carroll R. Roeder</p>		<p>14. MOTHER'S MAIDEN NAME XXXXXXXXX Anna M Humburg</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 212-20-3210</p>	
<p>17. INFORMANT Christ</p>		<p>ADDRESS Mrs Marie Kruelle 4515 Hampnett</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Part</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Malignant Hypertension</p>			
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY (Yes or No) Yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from 3/31 19 71 to 4/13 19 71 that (1) (we) last saw the deceased alive on 4/13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE J. Khoury</p>		<p>23B. DATE SIGNED 4/13/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) JACQUES KHOURY</p>		<p>23D. ADDRESS Union Memorial Hospital</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 4/16/71</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY New Cathedral</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 15 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.</p>		<p>ADDRESS Baltimore, Md</p>	

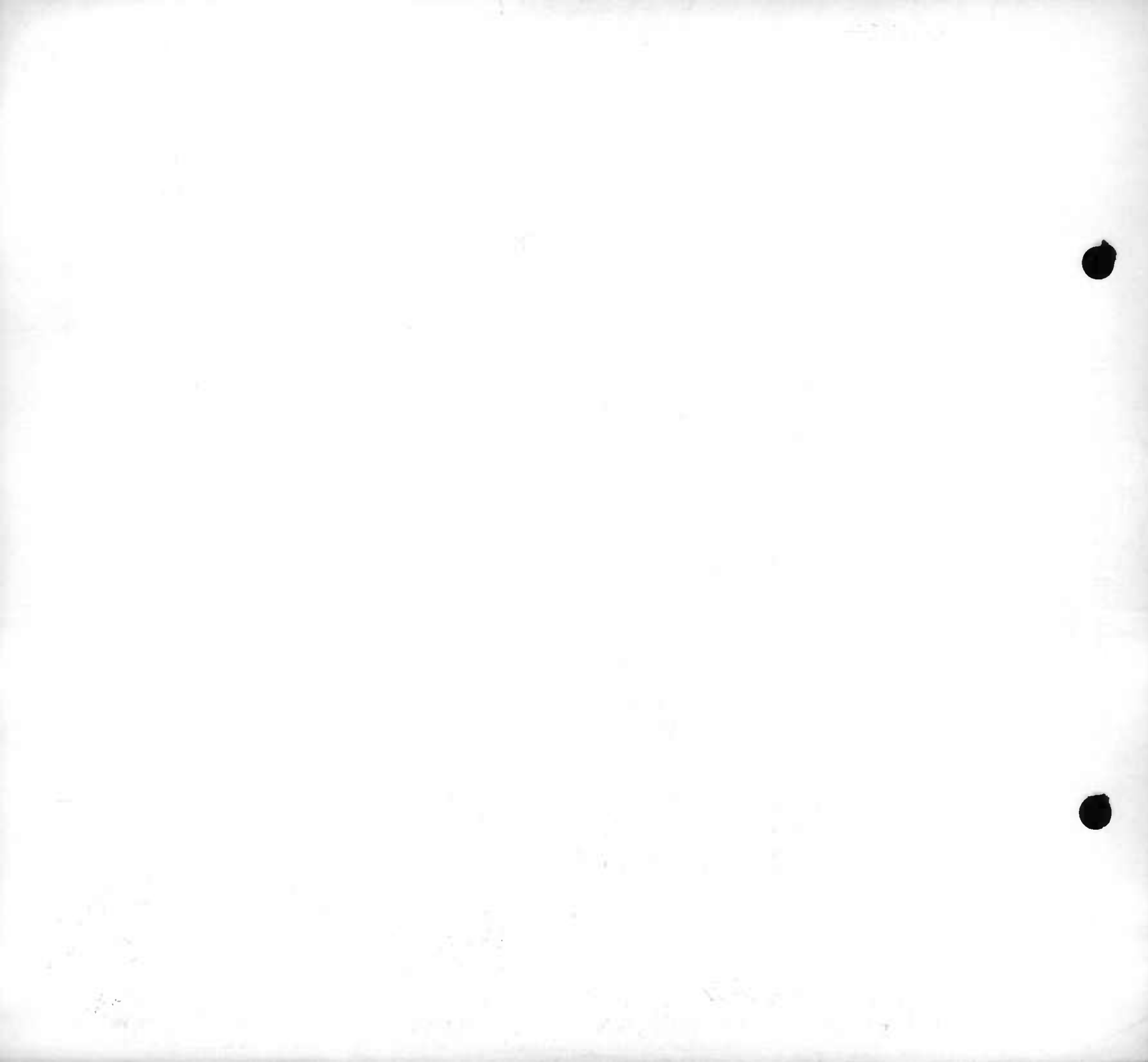


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W 252 71-08224</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3698</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Washington</u>			2. DATE AND HOUR OF DEATH <u>4/12/71</u> <u>12¹⁰ P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balt. city</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1919 Guilford Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/71</u>	9. AGE (In years last birthday) <u>3</u> <u>40</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			13. FATHER'S NAME <u>Richard Smith</u>		
14. MOTHER'S MAIDEN NAME <u>Washington</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>mother</u>		
18. <u>72281</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>4/12</u> 19 <u>71</u> to <u>4/12</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/12</u> 19 <u>71</u> and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William F. DeVoe MD</u>			23B. DATE SIGNED <u>4/12/71</u>		23C. PHYSICIAN'S NAME (Type) <u>—</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>			24B. DATE <u>4-15-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>—</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 16 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Bailey, R.R.</u>		25C. FUNERAL DIRECTOR <u>—</u>

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

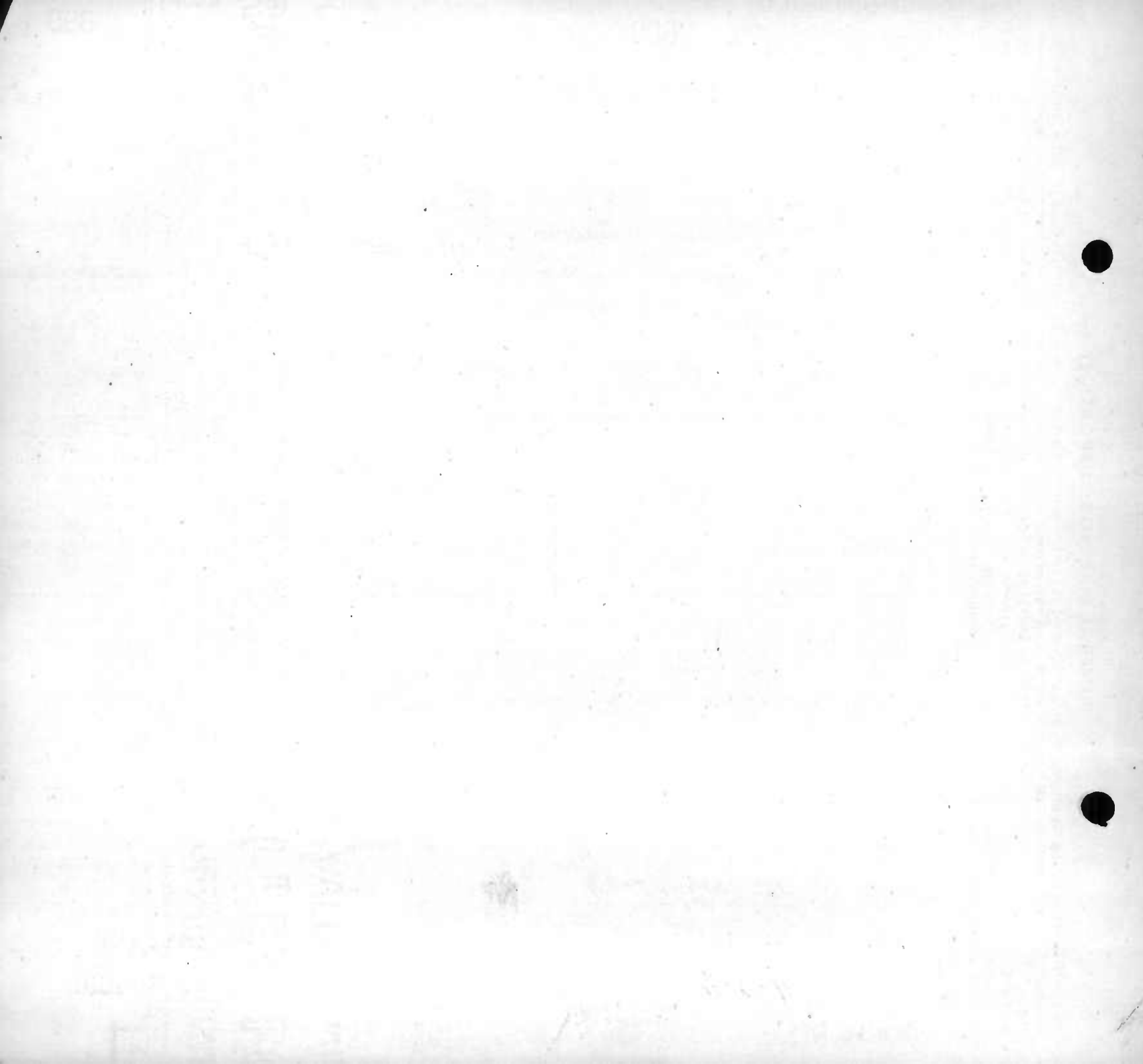


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	71 3699
W-300 BIRTH NO. 71-06723		71 3699			
1. NAME OF DECEASED (Type or Print)		BABY GIRL WHITE			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 4/8/71 10:15 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION U. M. H.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE M.D. B. COUNTY 1204	
5. SEX F		6. RACE NEGRO		C. CITY OR TOWN BALTO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/8/71		9. AGE (In years last birthday) new born	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M.D.	
13. FATHER'S NAME Charles		14. MOTHER'S MAIDEN NAME FRANCES WHITE		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 740X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANENCEPHALY (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/8/71 19 11 to 4/8/71 19 11, that (1) (we) last saw the deceased alive on 4/8/71 19 11 and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose M. De Leon		23B. DATE SIGNED 4/8/71		23C. PHYSICIAN'S NAME (Type) JOSE M. DE LEON	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-15-71		24C. NAME of CEMETERY or CREMATOR	
25A. DATE REC'D BY HEALTH DEPT. APR 16 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS	

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



71 3700

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3700

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD STEWART		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> April 14, 1971		Hour 6:20 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year April 14, 1971		Hour 6:20 P.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4/11/09		10. AGE (In years last birthday) 62		11. BIRTHPLACE (State, or foreign country) unknown
12. CITIZEN OF WHAT COUNTRY? unknown		13. FATHER'S NAME unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.
18. INFORMANT Elizabeth Cherry		19. CAUSE OF DEATH E9888X		20. ADDRESS 2020 Madison Ave
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro-cranial injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? ?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 15, 1971				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/71		24C. NAME OF CEMETERY or CREMATORY mt Calvary
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. APR 16 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR William J. McElroy		25D. ADDRESS 2302 W. North Ave		

ACADEMIC RECORD

1

B-620 71 3701 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3701

1. NAME OF DECEASED (Type or Print) SUSAN BERKOW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 14 1971 10:45a M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2730	
9. DATE OF BIRTH 3/25/1948		10. AGE (In years lost birthday) 23	
11. BIRTHPLACE (State or foreign country) 3/25/1948 md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Berkow		14. MOTHER'S MAIDEN NAME Ruth Grott	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Meprobamate overdose ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION 2	
21. DATE OF OPERATION 2		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. DATE OF OPERATION 2		24. AUTOPSY? (Yes or No) yes	
25A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
25C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2909 Fallstaff Road		25D. HOW DID INJURY OCCUR? Ingested overdose	
25E. TIME OF INJURY (APPROX.) 4-14-71		25F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
25G. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		25H. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
25I. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		25J. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
25K. DATE REC'D BY HEALTH DEPT. APR 16 1971		25L. NAME OF REGISTRAR Robert E. Galt	
25M. FUNERAL DIRECTOR Sylvan Lewis & Son		25N. ADDRESS 9610 Reisterstown Rd	
25O. BURIAL CREMATION, REMOVAL (Specify) Burial		25P. DATE 4/15/71	
25Q. NAME OF CEMETERY or CREMATORY Church Avenue		25R. LOCATION (City, town, or county) Balto	
25S. STATE md		25T. DATE 4/14/71	

VS 151-REV. 1/1/68

WALLEY FOR

25th 1st 1st

1/1/71

1/1/71

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

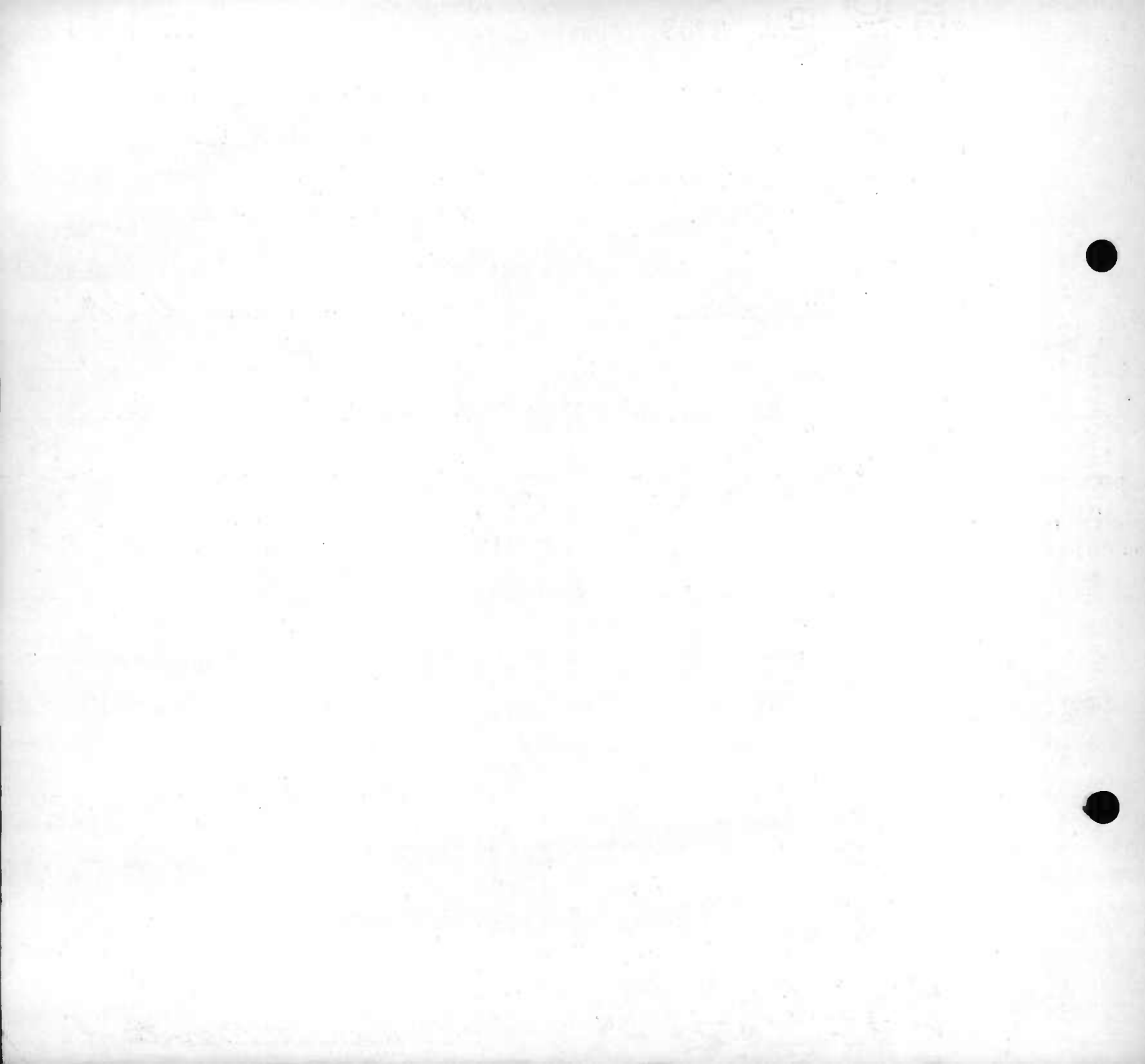
B-650 71 3702		BALTIMORE CITY HEALTH DEPARTMENT		71 3702	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) ROBERT BROWN			2. DATE AND HOUR OF DEATH 4-11-71 4:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING CENTER 90			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2101 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 644 MELVIN DR.		
5. SEX m	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-12	9. AGE (in years last birthday) 58	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DENNIS BROWN		14. MOTHER'S MAIDEN NAME SARAH BROWN	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-5794		17. INFORMANT ADMISSION RECORD MATTIE BROWN 644 MELVIN DR.	
18. 440.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE low pressure hydropneumothorax DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF: (C) arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/70 months years
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/6 19 71 to 4/11 19 71 that (I) (we) lost saw the deceased alive on 4/11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MARY			23B. DATE SIGNED 4/13/71		23C. PHYSICIAN'S NAME (Type) ALLAN H. MARY MD
23D. ADDRESS 2 E Red St Baltimore			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 4/16/71			24C. NAME OF CEMETERY OR CREMATORY UNION METHODIST		
24D. LOCATION (City, town, or county) (State) GOLDSBORO, MARYLAND			25A. DATE RECD BY HEALTH DEPT. APR 16 1971		
25B. NAME OF REGISTRAR Charles A. Rice			25C. FUNERAL DIRECTOR CHARLES A. RICE		
25D. ADDRESS 661 W. BARRE ST.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3703	
J-525 71 3703		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) George Jenkins		2. DATE AND HOUR OF DEATH April 14, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1013 Bennett Place Baltimore		A. STATE Maryland		B. COUNTY 1601	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1013 Bennett Place			
5. SEX Male	6. RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1908	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Labor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lawrence, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME George Jackson		14. MOTHER'S MAIDEN NAME Letitia Watkins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 241-07-8928		17. INFORMANT Annabell Jenkins	
18. 4/2/71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Failure		1 wk	
		(B) Atherosclerotic Heart		12 y	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from January 10, 1950 to April 14, 1971 , and that (I) (we) lost saw the deceased alive on April 3, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William C. Wade, M.D.		23B. PHYSICIAN'S NAME (Type) William C. Wade, M.D.		23C. ADDRESS 3005 Sunflower Rd., Dundalk, Md. 21222	
23D. DATE SIGNED		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 16 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Ed Wilson, 1001 Burnside Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500 71 3704				BALTIMORE CITY HEALTH DEPARTMENT		71 3704	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BEANE, FAVID A				4/15/71 9:00 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				Maryland 1601			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
Male Negro				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER			
Laborer construction				917 N. Arlington Ave			
13. FATHER'S NAME				8. DATE OF BIRTH 9. AGE (in years last birthday) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?			
Robert Ball				9/22/21 49 Baltimore, Md. USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS			
Yes 4/16/42 - 6/3/49				225-18-1205 VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF:				unknown			
(B) Tuberculosis extensive DUE TO, OR AS A CONSEQUENCE OF:				6-8 months			
(C) Metastatic liver disease secondary to				11A			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from February 22nd 19 71 to April 15th 19 71 that (I) (we) last saw the deceased alive on April 15th 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Ricardo A. Gordon M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Ricardo A. Gordon M.D.				3900 Loch Raven Blvd. Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/19/71		National Park		Gettysburg Pa	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 16 1971		Robert E. Halstead, M.D.		Adolphus Halstead 1206 W		14 North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3705</u>	
1. NAME OF DECEASED (Type or Print) <u>JOHNSON, MARGARETTE</u>		2. DATE AND HOUR OF DEATH <u>7 P.M. 4-14-71</u> <u>7P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2037</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>46</u>		F. STREET AND NUMBER <u>410 N. Edgewood Street</u>			
5. SEX <u>F.</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-03</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE [State or foreign country] <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert Brown</u>			
14. MOTHER'S MAIDEN NAME <u>Virginia Hall</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>no</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frank Johnson Sr.</u> ADDRESS <u>same</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslerio, etc. It means the disease, injury or complication which caused death.) <u>Cachexia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Dysphagia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH [Indify medical examined]		21B. PLACE OF INJURY [e.g., in or about home, farm, factory, street, office bldg., etc.]		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-8-71</u> to <u>4-14-71</u> that (I) (we) last saw the deceased alive on <u>4-8-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Govinda Rao</u>		23B. DATE SIGNED <u>4-14-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. R. Govinda Rao</u>	
23D. ADDRESS <u>Lutheran Hospital of Maryland</u>		23E. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>			
24A. BURIAL CREMATION, REMOVAL [Specify]		24B. DATE <u>4-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cem.</u>	
24D. LOCATION <u>Annapolis, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 16 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kelson F.H.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3706	
VV25271 3706		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		ROBERT WASHINGTON		2. DATE AND HOUR OF DEATH 04-15-71 1:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS H SPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 819 F. CHASE ST.	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-87	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE WASHINGTON		14. MOTHER'S MAIDEN NAME LUCINDA Venny	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 229-05-3597		17. INFORMANT Susie Young 819 Chase St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 274X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ? Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (B) Dehydration DUE TO, OR AS A CONSEQUENCE OF: (C) Hyperosmolar Nonketotic Hyperglycemia gout Hyperosmolar Nonketotic Hyperglycemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 11 days 11 days 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/7 1971 to 4/15 1971 that (1) (we) last saw the deceased alive on 4/15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey Brinker M.D.		23B. DATE SIGNED 4/15/71		23C. PHYSICIAN'S NAME (Type) Jeffrey Brinker M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-18-71		24C. NAME OF CEMETERY OR CREMATORY Mt Olive Church Cem.	
24D. LOCATION Northumberland Co., Va.		25A. DATE REC'D BY HEALTH DEPT. APR 16 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		25D. ADDRESS Kelson F.H. 1348 Calhoun Street			

33795

100-100000-1000000

100-100000-1000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3707</u>	
BIRTH NO. <u>71 3707</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>WIRONKA MARY</u>			2. DATE AND HOUR OF DEATH <u>4/15/71 1:15 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Essex St. 2232</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/94</u>	9. AGE (in years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food Packer</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Wojciech Slaba</u>			14. MOTHER'S MAIDEN NAME <u>Katarzyna Olszewski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-12-0184</u> <u>213 015151</u>	17. INFORMANT <u>Mrs. Cecelia Ham</u> ADDRESS <u>1216 Argonne Drive (18)</u> <u>Hosp. Chari</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>4/15</u> 19 <u>71</u> to <u>4/15</u> 19 <u>71</u> that (I) <u>(We)</u> last saw the deceased alive on <u>4/15</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>M.D. Barhanpurkar</u>				23B. DATE SIGNED <u>4/15/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>MADHAV D. BARHANPURKAR</u>		23D. ADDRESS <u>North Charles Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/19/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 16 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>George A. Weber - 705 S. Ann St. #21231</u>			

1891

1891

1891
1891
1891

1891

1891
1891

1891

1891

1891

1891

1891

1891

1891

1891

G-620

71 3708

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3708

BIRTH NO. 70-19195

1. NAME OF DECEASED
(Type or Print)

ANTWAN E. GROSS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

April 7, 1971

10:20P.

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10-21-70

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

725 George Street, Apt. 12M

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Paul A. Gross

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Augustine R. Burrell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Paul A. Gross 725 George St. Apt 12M

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Craniocerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home ?

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

-2- 725 George St. Apt. 12M

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) -2- Unknown22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

-2- Subject supposedly fell

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/8/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/12/71

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 16 1971

25B. NAME OF REGISTRAR

Robert E. Kelly, Jr.

25C. FUNERAL DIRECTOR

Wm C. March 928 E. North Ave.

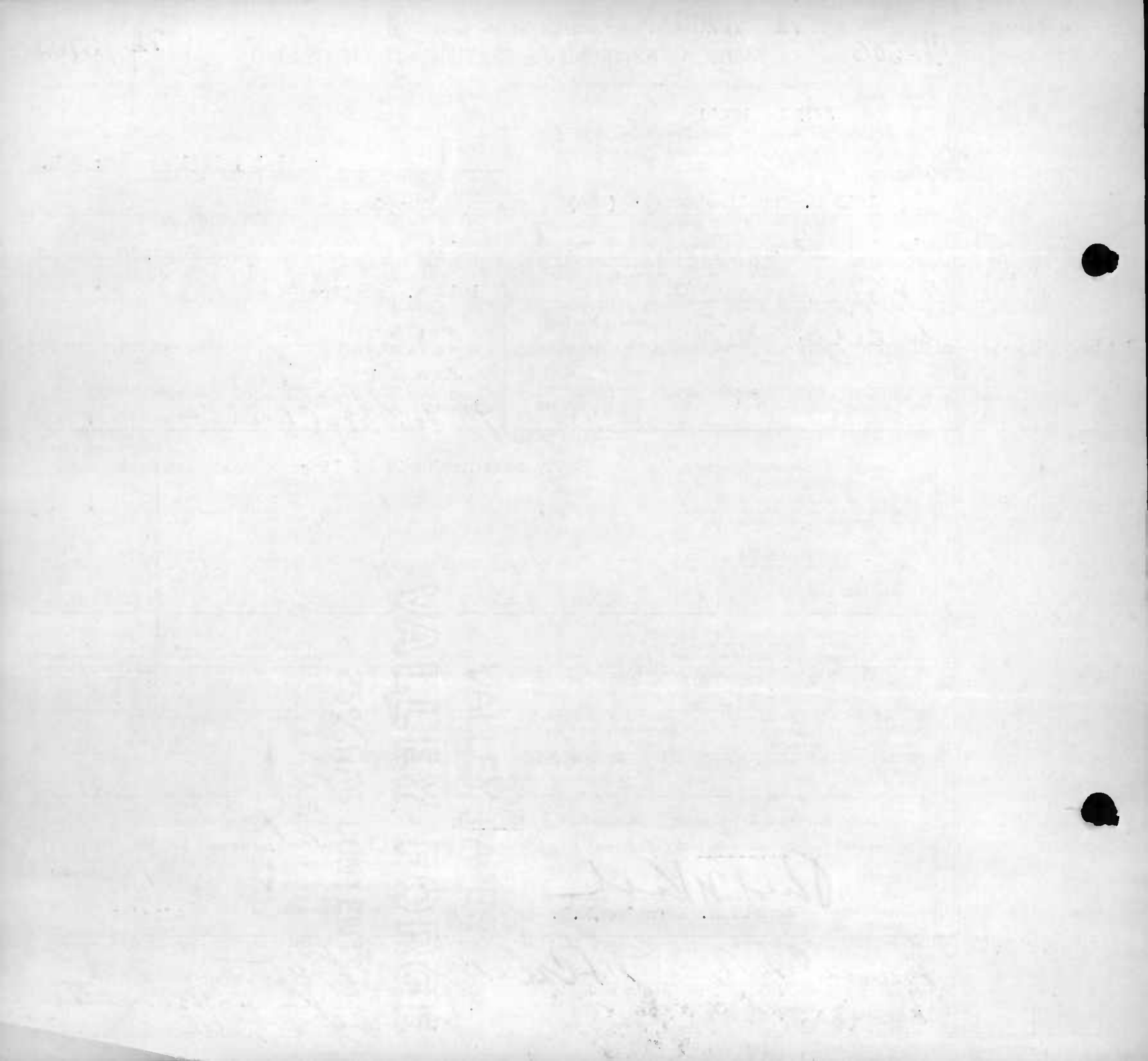
ADDRESS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

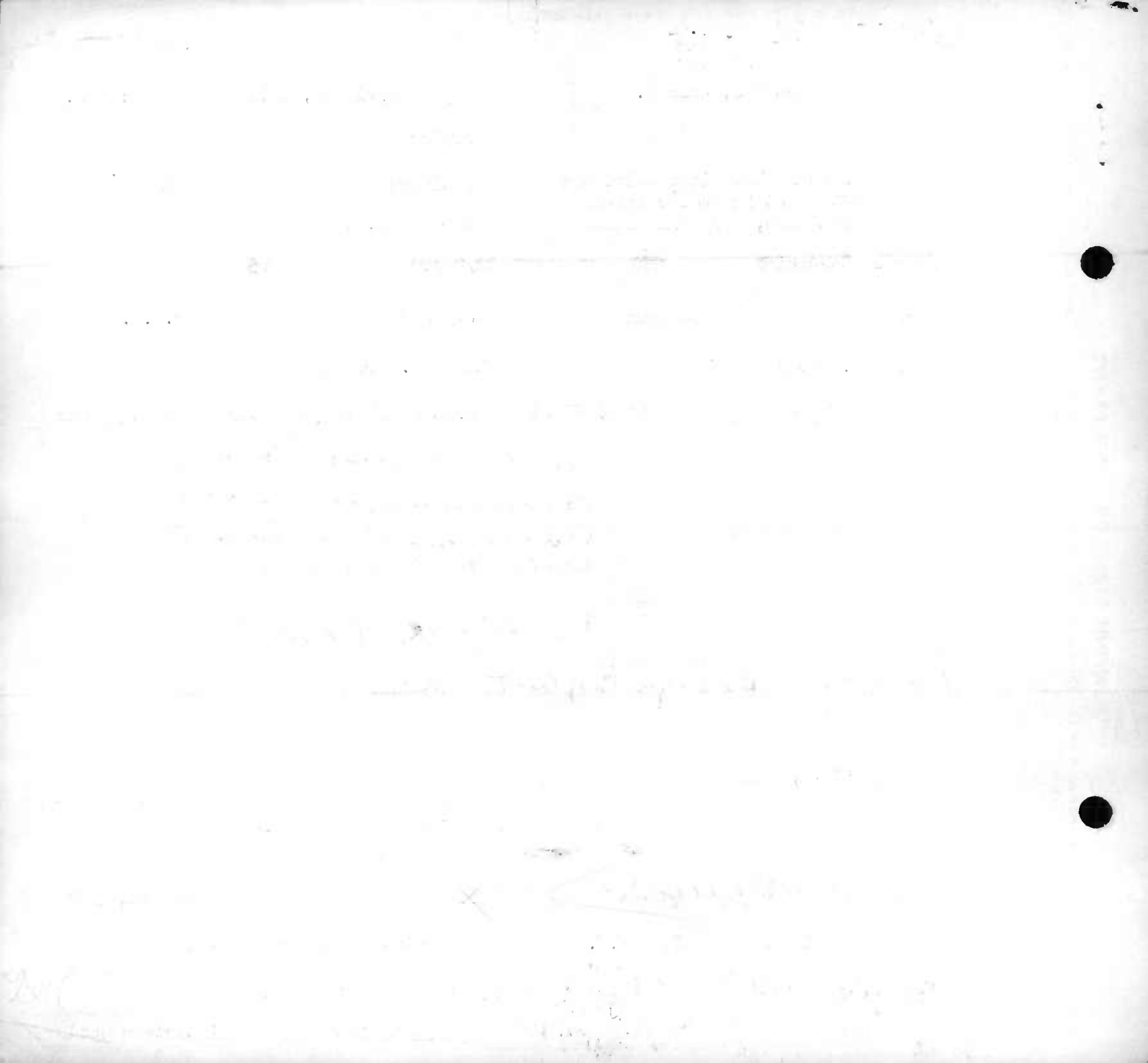
1. NAME OF DECEASED (Type or Print) JAMES MOORE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1013 N. Caroline Street (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1971 2:30 P.M.			
6. SEX Male				7. RACE Negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-6-37				10. AGE (In years lost birthday) 43		C. CITY OR TOWN Baltimore	
11. BIRTHPLACE (State or foreign country) Weldon, NC				12. CITIZEN OF - WHAT COUNTRY? USA		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 1013 N. Caroline Street	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Unknown	
18. INFORMANT James Moore				ADDRESS 1013 N. Caroline			
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 7-1-71				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/71							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial 4/17/71		4/17/71		St. Charles		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 19 1971		Robert E. Taylor, R.D.		Julius M. Carson		2302 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

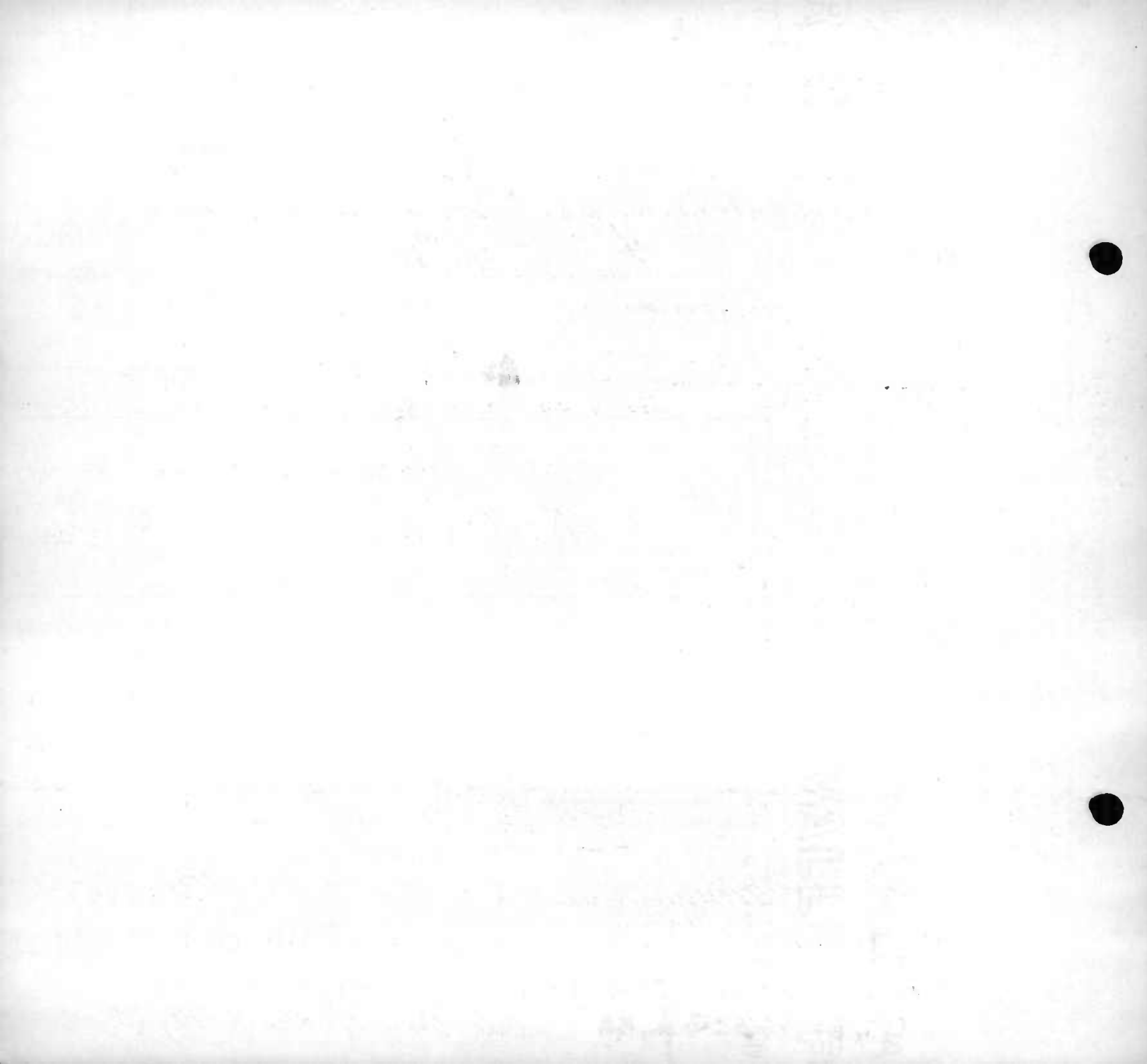
Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>71 3710</u>
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Goodman, Anna K.		April 15, 1971 11:20 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 House In The Pines Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 804 Judy Lane		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/95	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles A. Kothe		
14. MOTHER'S MAIDEN NAME Ellen J. Stevenson		15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO. 218-10-6931D		17. INFORMANT Dorothy Seidel (daughter)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Respiratory Failure B) CARDIOVASCULAR Carcinoma of the Breast DUE TO, OR AS A CONSEQUENCE OF: Metastasis C) EX (Hip @ pinned).		
19A. DATE OF OPERATION 3/15/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex hip - Car Bone		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 804 JUDY LANE		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) April 15, 1971 9:30 PM		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? ACCIDENTALLY FELL		
22. I certify that (I) (this hospital) attended the deceased from Apr 25 19 63 to APR 15 19 71 that (I) (we) last saw the deceased alive on Apr 15 19 71 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.				
23A. SIGNATURE Willard Applefeld M.D.		23B. DATE SIGNED April 15, 1971		23C. PHYSICIAN'S NAME (Type) Willard Applefeld M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/71		24C. NAME OF CEMETERY or CREMATORY Chapel Ameno
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md		
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Garbay, M.D.		25C. FUNERAL DIRECTOR Sylvan Lewis & Son
25D. ADDRESS Reistertown Road		25E. ADDRESS Reistertown Road		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3711	
BIRTH NO. K-400		71 3711		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELIZA STARKEY KYLE			2. DATE AND HOUR OF DEATH 5 APRIL 1971 11:25 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME + HOSPITAL BROADWAY - BALTO. MD.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD 8. COUNTY 703 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 608 N. COLLINGTON AVE.		
5. SEX FEM.	6. RACE WHITE.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1885	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME C. STARKEY			
14. MOTHER'S MAIDEN NAME CATHERINE (?)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 234-14-2500		17. INFORMANT MRS. JASSEN KRAJER - WESTMINSTER, MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ischemic Heart disease (B) ASCD (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 2 yrs			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 4 1971 to April 5 1971 , that (I) (we) last saw the deceased alive on April 4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Leo M. Bunnyardner				23B. DATE SIGNED April 15/71	
23C. PHYSICIAN'S NAME (Type) G.M. JHONAGARDNER, MD		23D. ADDRESS 8552 PHILADELPHIA RD. BALTO. CO. MD			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4/8/71	24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR D. P. Kelly		25C. FUNERAL DIRECTOR D. P. Kelly	



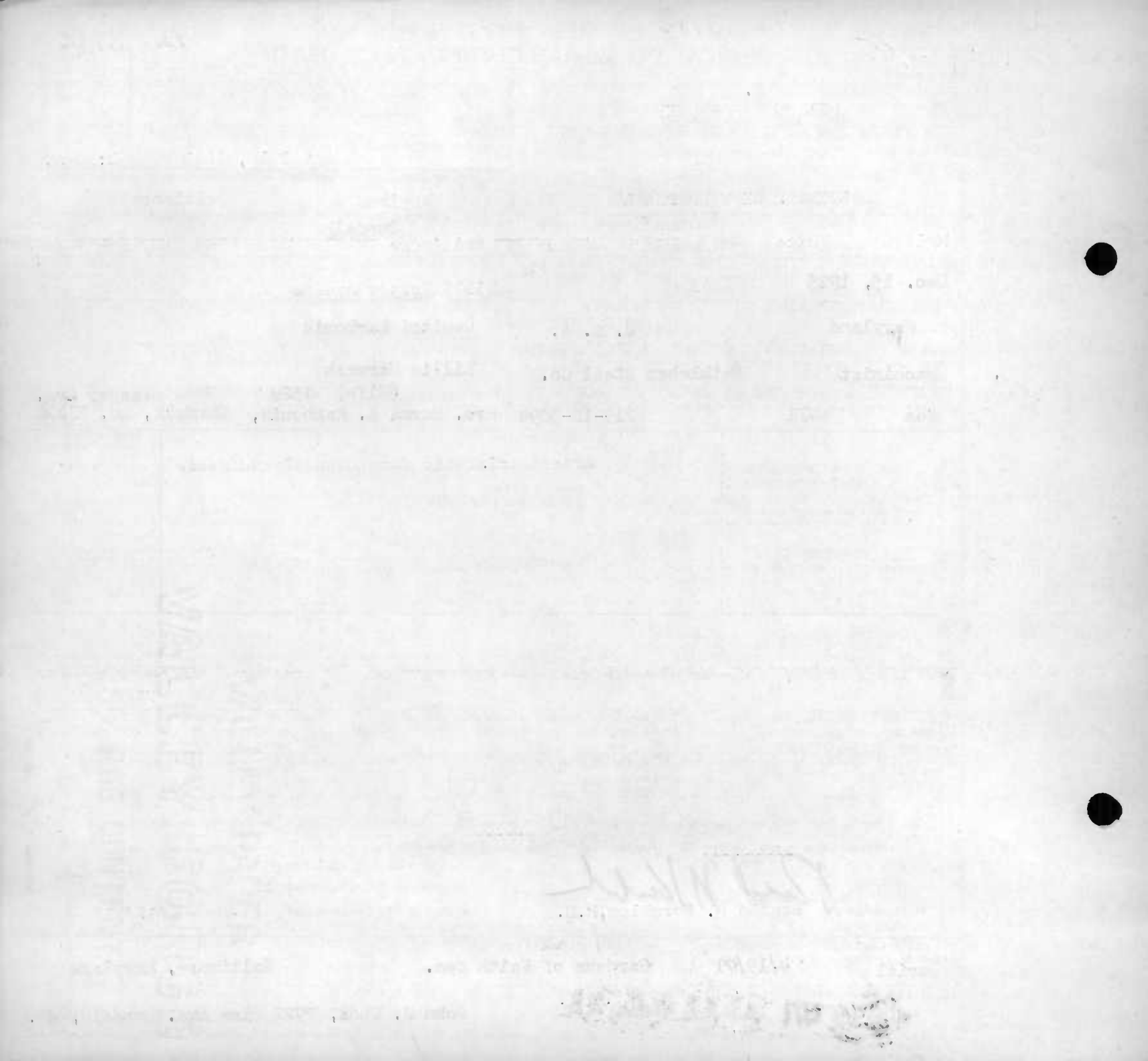
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 3712

BIRTH NO.

REG. NO.

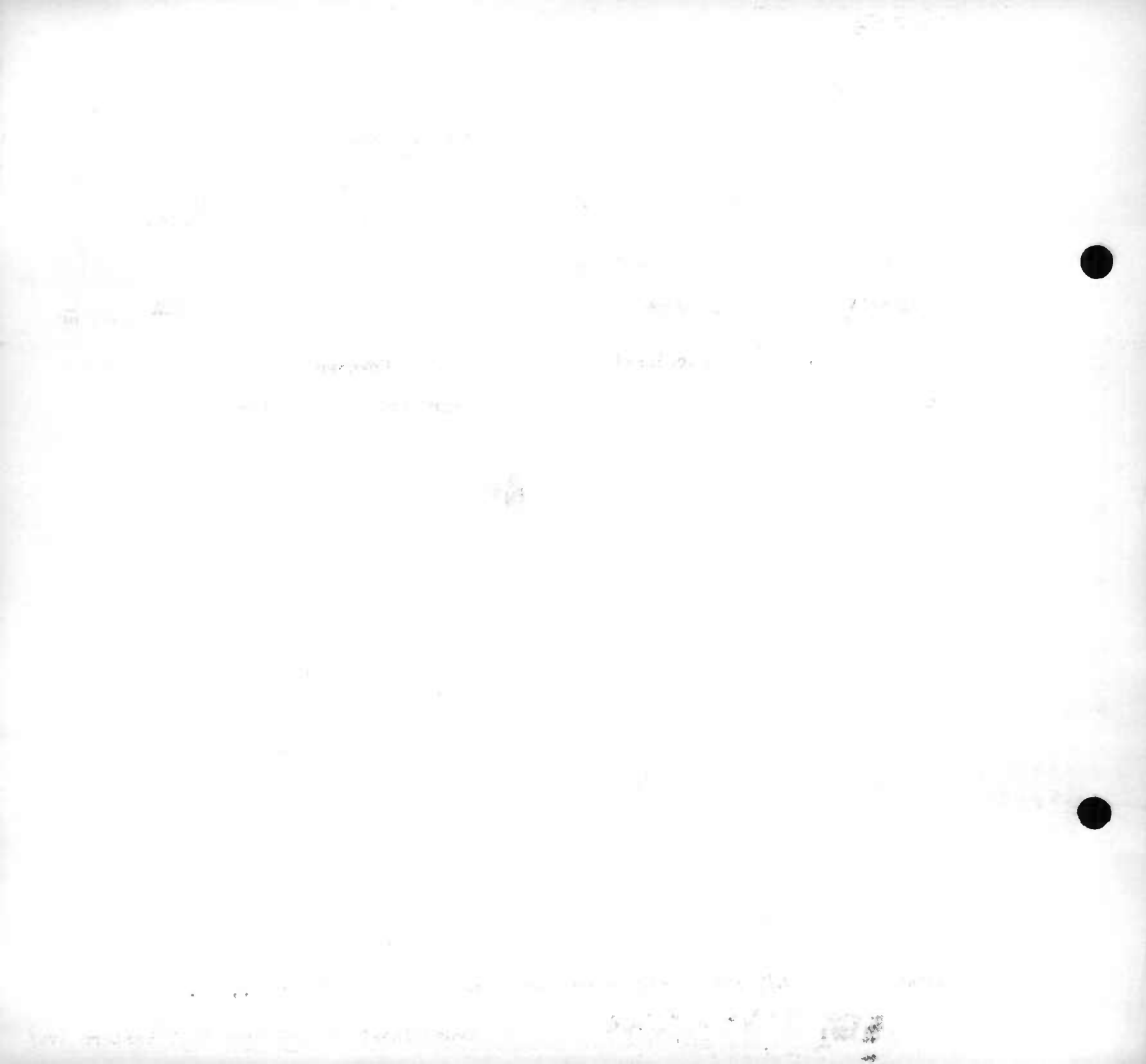
1. NAME OF DECEASED (Type or Print) MILTON KARBONIK				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour April 16, 1971 3:30 A.M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300				6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH Dec. 15, 1925		10. AGE (In years last birthday) 45		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Demitri Karbonik		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		15. MOTHER'S MAIDEN NAME Lillie Marmash		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII	
17. SOCIAL SECURITY NO. 219-10-3094		18. INFORMANT (Wife) 1529 ADDRESS Vesper Ave. Mrs. Norma A. Karbonik, Dundalk, Md. 21222		19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/71		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME of REC'D BY		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

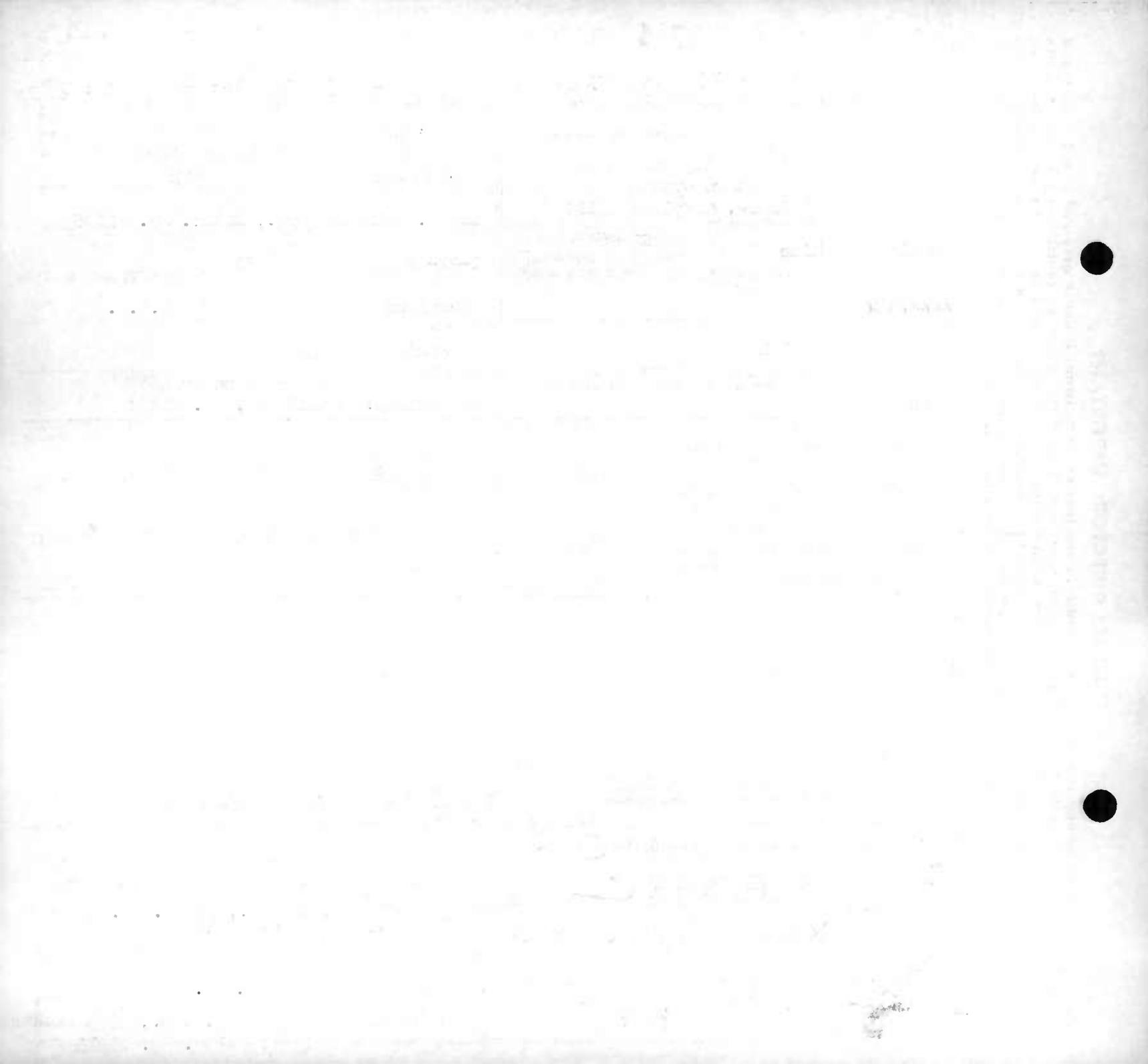
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3713
1. NAME OF DECEASED (Type of Person) MRS. MARY A. KACZMARCZYK		2. DATE AND HOUR OF DEATH April 14, 1971 9:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital 2025 W. JAYETTE ST.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Howard Co. C. CITY OR TOWN COLUMBIA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 10750 Evening Wind Court		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/92	9. AGE (in years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) WARSAW, POLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Kuchinski		
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 189-03-1715		17. INFORMANT Nora Paige ADDRESS Same		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease Coronary heart failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 12 years 48 hours
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from April 12 19 71 to April 14 19 71 that (I) (we) last saw the deceased alive on April 14 19 71 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Chum Sak Pruksapong M.D.		23B. DATE SIGNED April 14, 1971		23C. PHYSICIAN'S NAME (Type) CHUMSAK PRUKSA PONG M.D.
23D. ADDRESS Bon Secours Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4/17/71		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Bruzdinski		25C. FUNERAL DIRECTOR Bruzdinski Funeral Home 1407 Eastern Ave/



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-523		71 3714		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3714	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Wingate, Katharine				4-13-71 1:00 PM 10:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
31		Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		702	
5. SEX		6. RACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female		White		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER		604 N. Lakewood Ave., Balto. Md. 21205	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
1-22-08		63		Housewife		Maryland	
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
John Walsh		Annie Heuther		no		17. INFORMANT ADDRESS 4940 Eastern Avenue BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiorespiratory arrest few min.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cirrhosis of liver many yrs.			
				(C) Renal failure (uremia) few wks.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3-29-1971 to 4-13-1971 that (I) (we) last saw the deceased alive on 4-13-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
K. AFSARI				4-13-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
K. Hosrow AFSARI M.D.				4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
burial				4/17/71		Gardens of Faith Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 19 1971				Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21213			



1

M-600 71 3715

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3715

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DONALD MOORE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 405 N. Linwood Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 14 1971 2:18 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 601	
9. DATE OF BIRTH 2/10/27		10. AGE (In years lost birthday) 44	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Orlando Moore		14. STREET AND NUMBER 405 N. Linwood Ave.	
15. MOTHER'S MAIDEN NAME Louise Johnson		16. INFORMANT (sister) Mrs. Virginia Sterling 617 N. Rose St.	
17. SOCIAL SECURITY NO. 217-20-5242		18. ADDRESS 617 N. Rose St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
29. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		30. DATE SIGNED 4/14/71	
31. BURIAL CREMATION, REMOVAL (Specify) burial		32. DATE 4/17/71	
33. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		34. LOCATION (City, town, or county) (State) Balto. Md.	
35. DATE REC'D BY HEALTH DEPT. APR 19 1971		36. NAME OF REGISTRAR Robert E. Taylor, M.D.	
37. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto., Md. 21213		38. ADDRESS	

VS 151-REV. 1/1/68

WALTER E. FORD

WALTER E. FORD

9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-252 71 3716		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3716	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BUKUNSTEIN, CHARLES		2. DATE AND HOUR OF DEATH 4-13-71 11:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-36		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1227 Raleigh Way, Balto. Md. 21224	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-98	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY U.B.E.E.Y. Trucking Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Buxenstein		14. MOTHER'S MAIDEN NAME Fannie Baker	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-03-6565A		17. INFORMANT BCH Records: ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (A) Immediate cause (B) Congestive heart failure 2 weeks (C) A.S.C.V.D. - 3 years		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Probable pneumonia			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-5 19 71 to 4-13 19 71 that (I) (we) last saw the deceased alive on 4-13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. DeWayne Andrews, M.D.				23B. DATE SIGNED 4-13-71	
23C. PHYSICIAN'S NAME (Type) M. DeWayne Andrews, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/17/71		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR Robert E. Taylor, R.D.		24F. FUNERAL DIRECTOR Schimunek, Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21201	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

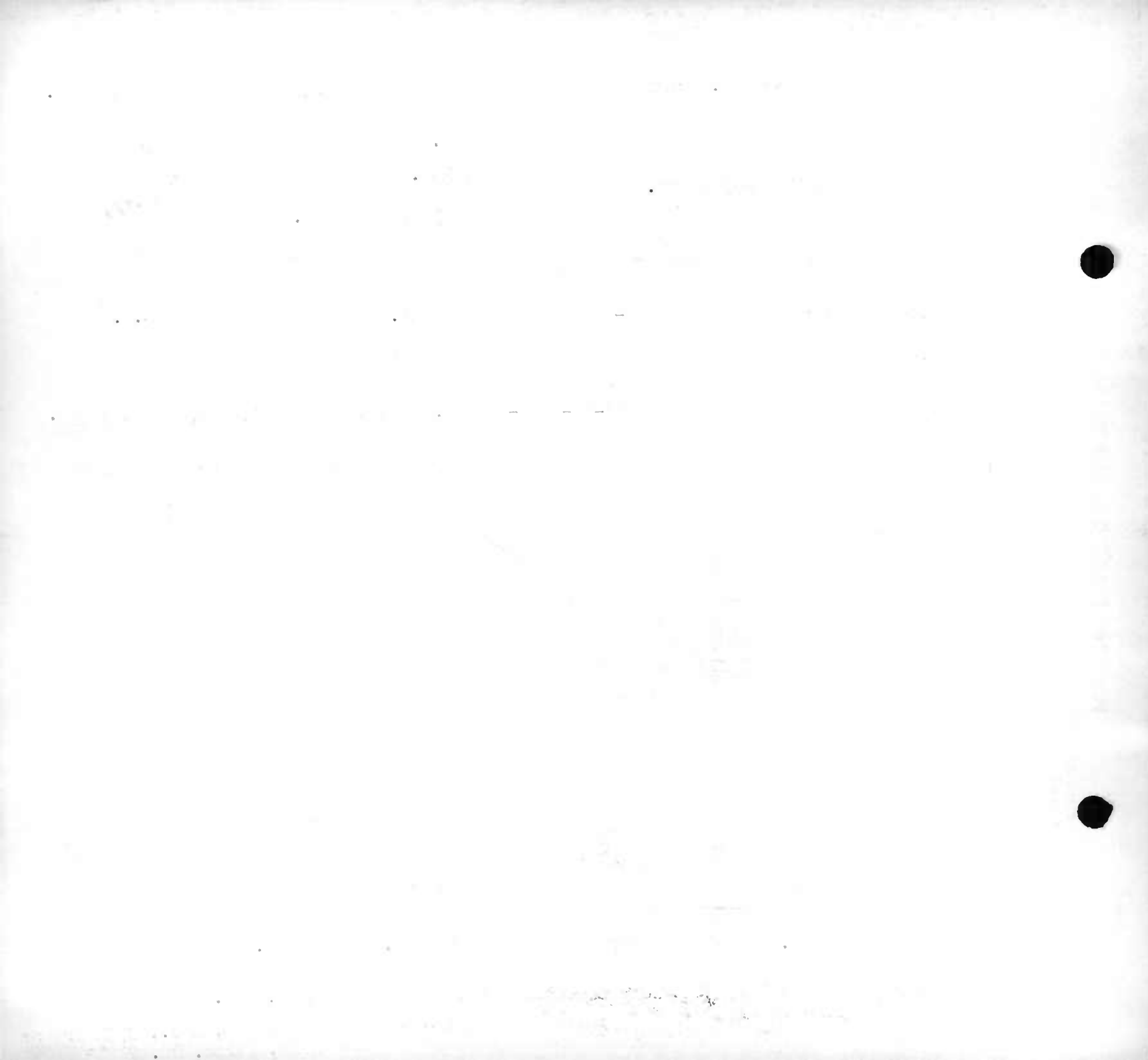
BIRTH NO.		71 3717		BALTIMORE CITY HEALTH DEPARTMENT		71 3717	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) Meta E. Butler				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 12 71 11:55 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 00 2630 McElderry St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 12 71 11:55 a.m.			
6. SEX female				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1/10/87				10. AGE (In years last birthday) 84		11. BIRTHPLACE (State or foreign country) Balto.	
12. CITIZEN OF US				13. FATHER'S NAME John Edelman		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 702	
15. MOTHER'S MAIDEN NAME Annie Veitch				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Calvin R. Schutz, 3330 Strickland St.				19. CAUSE OF DEATH (nephew) Arteriosclerotic cardiovascular disease		20. ADDRESS Balto. Md.	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Carcinoma of breast				24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				33. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, MD		34. DATE SIGNED 4/12/71	
35. DATE REC'D BY HEALTH DEPT. APR 19 1971				36. NAME OF REGISTRAR Q. J. E. Kelly, Jr.		37. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21213	
38. BURIAL CREMATION, REMOVAL (Specify) burial				39. DATE 4/15/71		40. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
41. LOCATION (City, town, or county) Balto. Md.				42. STATE Md.		43. COUNTY 702	

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3718</u>	
<u>S-150</u> <u>71 3718</u> BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Harry B. Spahn</u>		2. DATE AND HOUR OF DEATH <u>4/11/71</u> <u>11:35 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4003 Woodlea Ave.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2741</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4003 Woodlea Ave.</u>			
5. SEX <u>M</u> 6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/16/90</u> 9. AGE (In years last birthday) <u>80</u>		If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tavern owner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Spahn</u>		14. MOTHER'S MAIDEN NAME <u>Ann Hofnagle</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-32-9550-A</u>		17. INFORMANT (daughter) <u>Mrs. Anna Mae Weibler, 4003 Woodlea Ave.</u>	
18. <u>4109 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2-2</u> 19 <u>61</u> to <u>4-11-71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>Dr. H. H. S. pronounced death</u>					
23A. SIGNATURE <u>Dr. Francis Carmody</u>				23B. DATE SIGNED <u>4-14-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Francis Carmody</u>				23D. ADDRESS <u>3201 N. Charles St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/15/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>			
25B. NAME OF REGISTRAR <u>3212 E. E. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR <u>Schimunek, Funeral Homes, Inc., 3331 Brehms Lane, Balto., Md. 21213</u>			



BIRTH NO. <u>M-460</u>		71 3719		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. <u>71 3719</u>	
1. NAME OF DECEASED (Type or Print) <u>ELIZABETH MILLER</u>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>4 10 1971 2 p</u> M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2610</u>			
6. SEX <u>female</u>		7. RACE <u>white</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>4/19/14</u>		10. AGE (In years lost birthday) <u>56</u>		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <u>3221 Mc Elderrey St., Balto. Md. 21205</u>			
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frederick Miller</u>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				14B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		15. MOTHER'S MAIDEN NAME <u>Amelia Raulin</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				17. SOCIAL SECURITY NO. <u>-</u>		18. INFORMANT <u>Mrs. Margaret Acor, 1512 Lochwood Rd.</u>			
19. <u>412.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pulmonary embolus, recent</u>									
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Isidore Mihalakis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		<u>4/11/71</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/14/71</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Matthews Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>		ADDRESS			

Letter from M.E.'s office 6-1-71 M.H.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Stella MAY WINDHORST		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		Month Day Year Hour 4 13 1971 10:15 P.M.		Union Memorial Hospital (DOA)		A. STATE Pa. B. COUNTY K-35	
6. SEX female		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 5/20/94		10. AGE (In years lost birthday) 76	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME -- HERRING		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		14B. KIND OF BUSINESS OR INDUSTRY SALVATION ARMY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 807 20 1662		18. INFORMANT PAUL WINDHORST 2814 HUDSON ST.		15. MOTHER'S MAIDEN NAME		ADDRESS BALTO., MD.	
19. 412.4 I		CAUSE OF DEATH		Arteriosclerotic cardiovascular disease		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		EXAMINER'S NAME (Type) Asidore Mihalakis, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		4/14/71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/17/71		24C. NAME OF CEMETERY or CREMATORY Mt. ROYAL		24D. LOCATION (City, town, or county) (State) PITTSBURGH, PA.			
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK ROAD BALTO., MD.					

2180194

76

PENNA.

USA

HERRING

SALES

SAVATION ARMY

BALTO. MD.

807 SO 1862 PAUL WINDHORST 2814 HUNSON ST.

SALES

PITTSBURGH, PA.

MT. ROYAL

4117171

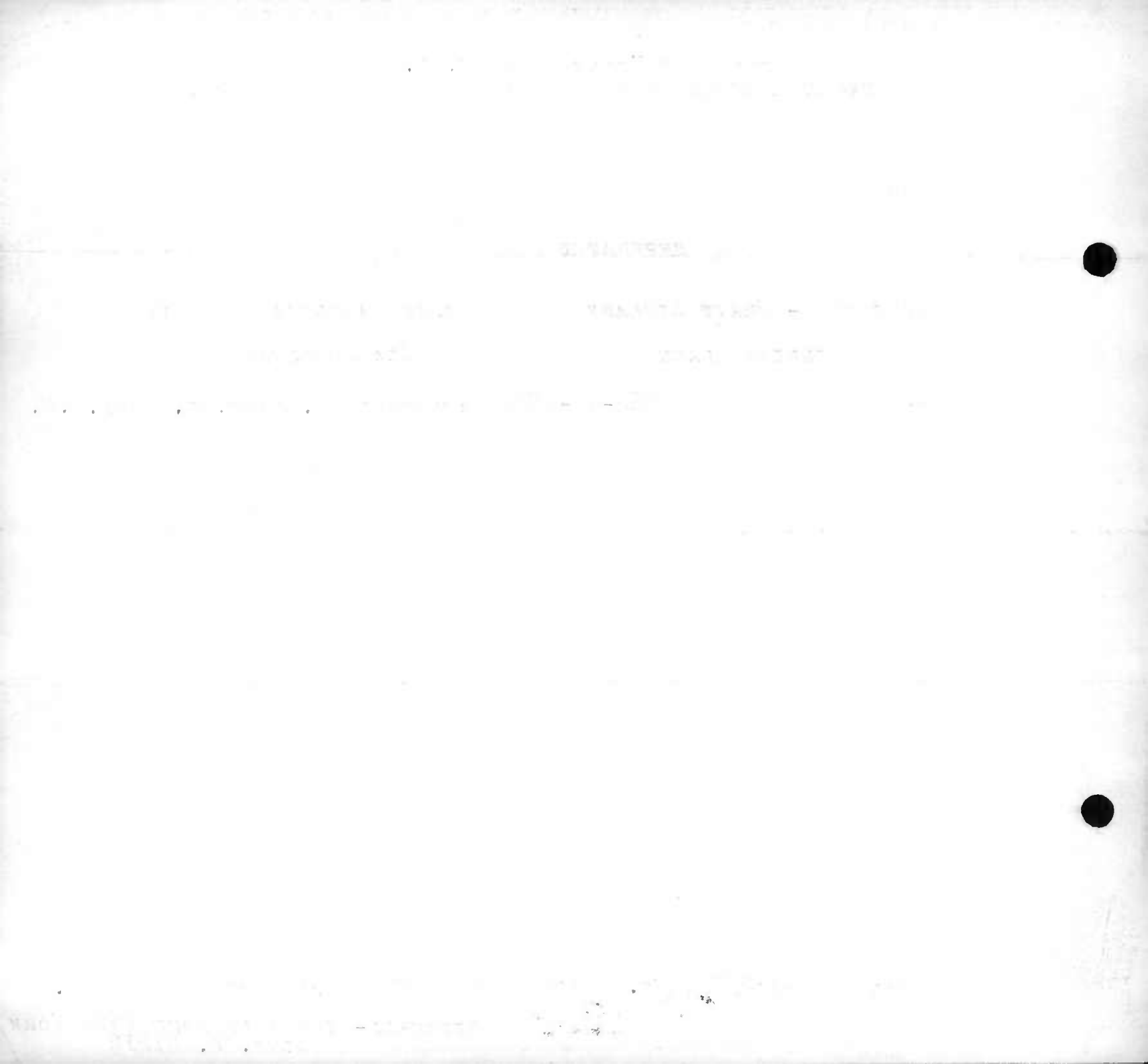
BURIAL

MITCHELL-WHEELER HOME
5500 YORK ROAD B LTO. MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

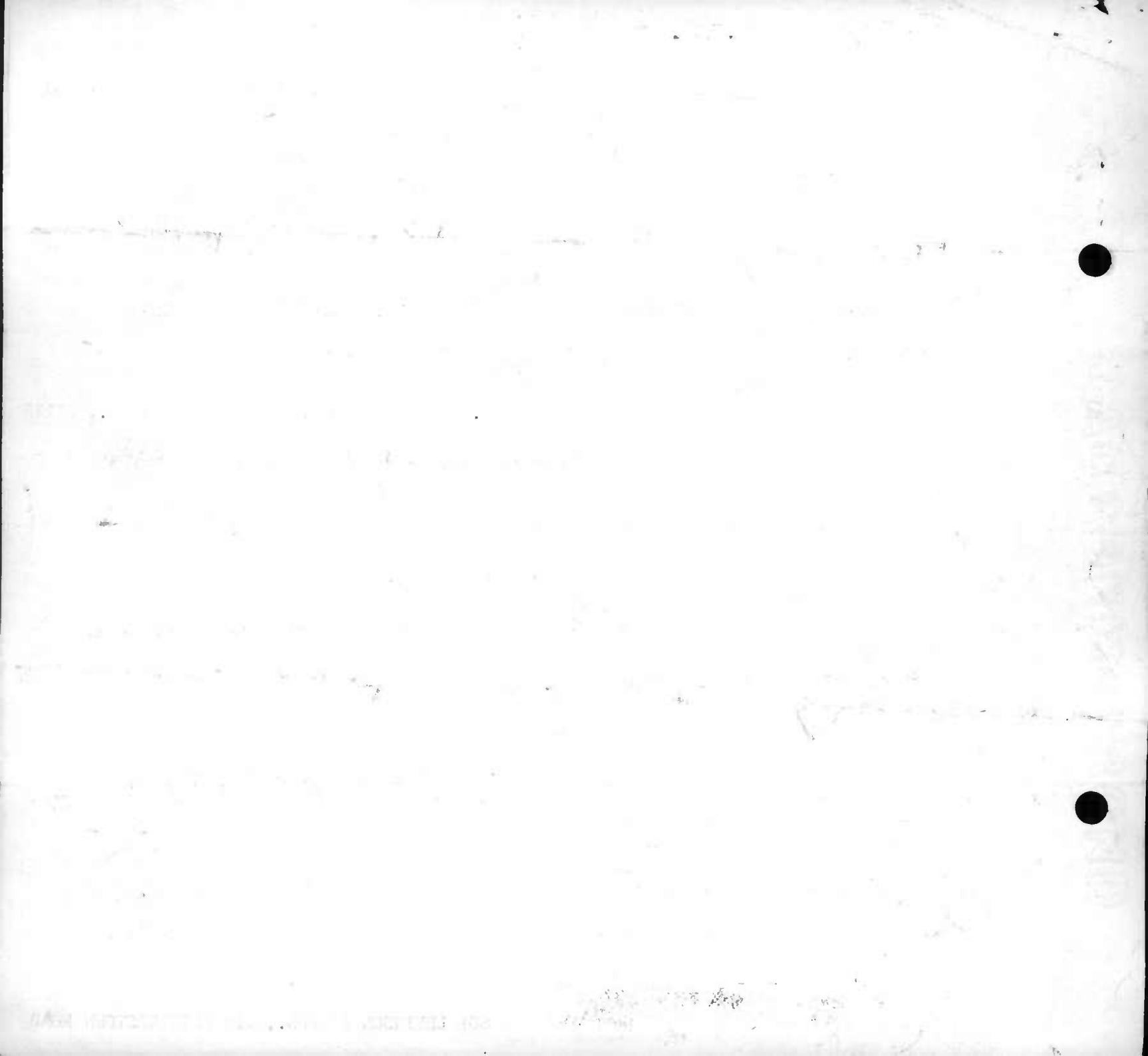
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3721	
CERTIFICATE OF DEATH					
BIRTH NO. 71 3721		1. NAME OF DECEASED (Type or Print) ROULPHARD WILLIAM BLACK, Sr.			
2. DATE AND HOUR OF DEATH 4/10/71 8:12 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD XXXXXXX XXXXXXXX BLACK			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 1203		5. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER 2707 St Paul		7. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital			
8. SEX M	9. RACE N	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH 3-29-13	12. AGE (In years last birthday) 58	13. Under 1 Yr. Months Days 14. Under 24 Hrs. Hours Min.
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR - PRATT LIBRARY		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
18. FATHER'S NAME WILLIAM BLACK		19. MOTHER'S MAIDEN NAME ADA WOODRUFF		20. CITIZEN OF WHAT COUNTRY? USA	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		22. SOCIAL SECURITY NO. 239-05-6660		23. INFORMANT ADDRESS RAULPHARD WM. BLACK, JR. WASH. D.C.	
24. CAUSE OF DEATH					
25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Calcium deposits				26. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				28. DUE TO, OR AS A CONSEQUENCE OF:	
29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
30. DATE OF OPERATION 4-9-71		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? (Yes or No)	
33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
36. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		37. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		38. HOW DID INJURY OCCUR?	
39. I certify that (I) (this hospital) attended the deceased from 4-9 19 71 to 4-10 19 71 that (I) (we) last saw the deceased alive on 4/10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
40. SIGNATURE Bayan B. Elma, M.D.				41. DATE SIGNED 4/10/71	
42. PHYSICIAN'S NAME (Type) BAYAN B. ELMA, M.D.				43. ADDRESS Md. 4th St 827 Linden Ave BALTO Md.	
44. BURIAL CREMATION, REMOVAL (Specify) BURIAL		45. DATE 4/15/71		46. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY	
47. DATE REC'D BY HEALTH DEPT. APR 19 1971		48. NAME OF REGISTRAR James E. ...		49. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HONE 6500 YORK BALTO. MD. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

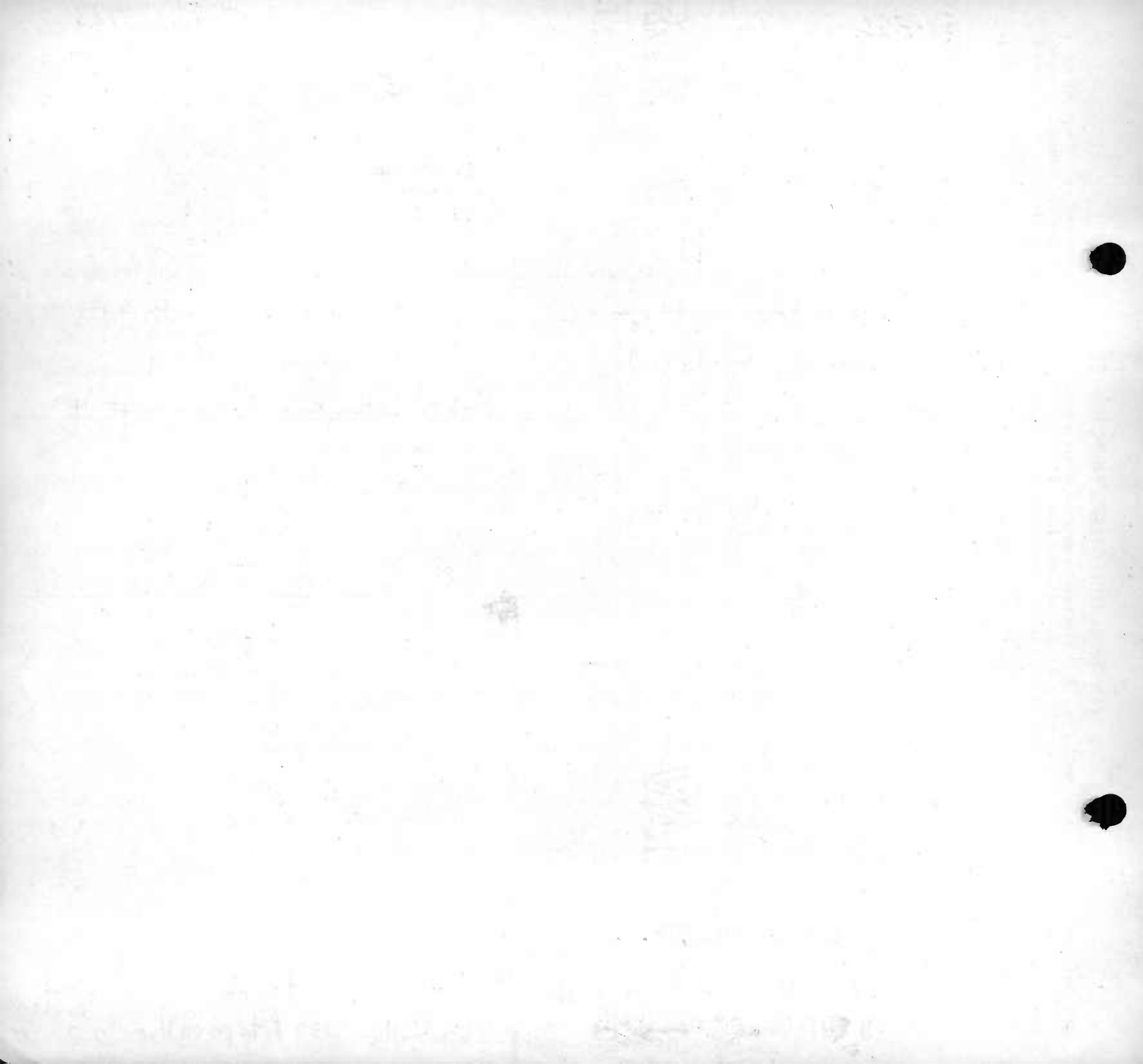
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3722</u>
BIRTH NO. <u>S-362 71 3722</u>		1. NAME OF DECEASED (Type or Print) <u>PEARL STRAUSS</u>		
2. DATE AND HOUR OF DEATH <u>4/14/1971</u> <u>3:05 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>42</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>5452 OLD COURT ROAD</u>				
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MORRIS ISAACS</u>		
14. MOTHER'S MAIDEN NAME <u>LENA ROSENBERG</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MR. MORRIS STRAUSS, 5452 OLD COURT RD., #21133</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Renal Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Multiple venous occlusion</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>Ex @ hip</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Parkinsonism</u> <u>Arteriosclerotic vascular disease</u>				
19A. DATE OF OPERATION <u>14/8/1971</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ex @ hip</u>	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>5452 Old Court Rd 53-00</u>		
21D. TIME OF INJURY (APPROX.) <u>3/31/1971</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>Fell out back truck</u>		
22. I certify that (H) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>71</u> to <u>4/14</u> , 19 <u>71</u> ; that (H) (we) lost saw the deceased alive on <u>4/14</u> , 19 <u>71</u> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Verapon Towannasut M.D.</u>		23B. DATE SIGNED <u>4/14/71</u>		23C. PHYSICIAN'S NAME (Type) <u>VERAPON TOWANNASUT M.D.</u>
23D. ADDRESS <u>SINAI HOSP. OF BALTO.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4-15-71</u>	24C. NAME of CEMETERY or CREMATORY <u>BNAI REUBEN</u>	24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>SOL LEVINSON & BROS.</u>		
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u>		ADDRESS <u>6010 REISTERSTOWN ROAD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

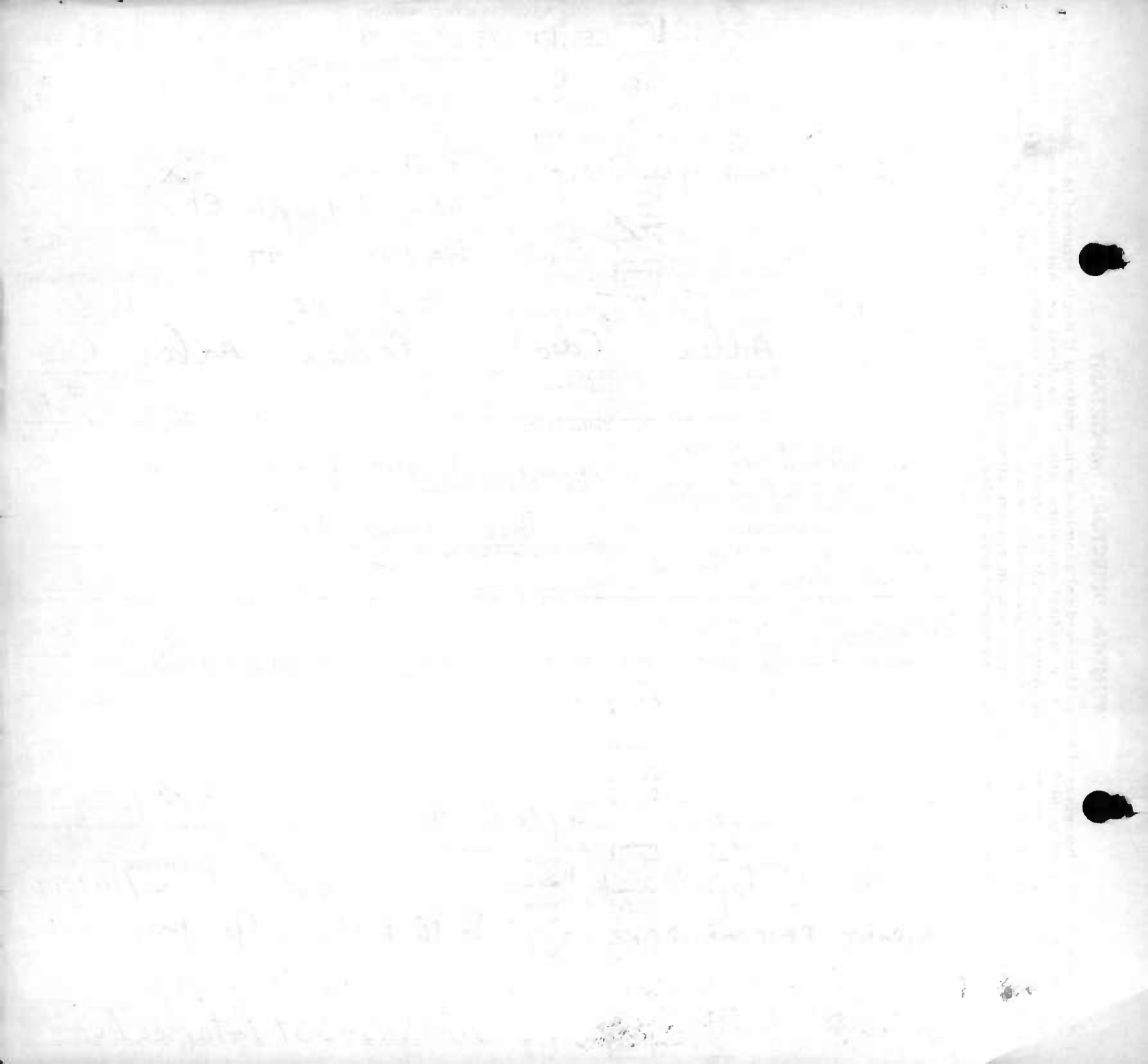
<div style="display: flex; justify-content: space-between;"> S-326 71 3723 </div>		<div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH </div>		<div style="display: flex; justify-content: space-between;"> REG. NO. 71 3723 </div>	
1. NAME OF DECEASED (Type or Print) Mary Stecker		2. DATE AND HOUR OF DEATH 15 April 1971 4:15 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore, Maryland 21239		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Rivera Beach D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 206 Hilltop Road			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/03/28	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balto. md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME YKw. Calvert		14. MOTHER'S MAIDEN NAME Catherine Day	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robt. E. Stecker - same as # 4	
18. 7/2/3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Poss Pulm Embolus (B) Hypoxemia DUE TO, OR AS A CONSEQUENCE OF: (C) Pneumothorax			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Tomasulo MD		23B. DATE SIGNED		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Peter Tomasulo, M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-20-71		Cedar Hill Cemetery Balto. AA	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Md.		APR 19 1971			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Robert E. Stecker		McCully		237 Knapscro Ave 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3724	
BIRTH NO. A-346		71 3724		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SAMUEL ARTHUR ADLER			2. DATE AND HOUR OF DEATH 4/16/71 2:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2505		
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore Gen. Hosp. 43			5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER 1103 Edwight St.			7. SEX M 8. RACE W		
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. DATE OF BIRTH 6/5/93 11. AGE (In years lost birthday) 77		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY T.V. Repairman		
11. BIRTHPLACE (State or foreign country) Baltimore			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Levi Adler (dec)			14. MOTHER'S MAIDEN NAME Rachel Adler (dec)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Beatrice Adler same as #4			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-pulmonary arrest (B) Poss. acuti MI. (C)		
19. DATE OF OPERATION 2-			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) Yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/14 19 71 to 4/16 19 71 that (I) (we) last saw the deceased alive on 4/16 19 71 and that in (my) (our) opinion death occurred on the date 4/16 19 71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nirant Rajadranuraks, M.D.			23B. DATE SIGNED 4/16/71		
23C. PHYSICIAN'S NAME (Type) NIRANT RAJADRANURAKS, M.D.			23D. ADDRESS South Baltimore Gen. Hosp.; Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR McCully	
25C. FUNERAL DIRECTOR 237 Patapsco Ave		25D. ADDRESS 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
S-100		71 3725		X		REG. NO.		71 3725	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
				Helen A. Sapp			4-13-71 1:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 38 Univ of Md Hospital				A. STATE Md			B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 223 Clarendon Ave					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-07	9. AGE (in years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Vincent Zito				14. MOTHER'S MAIDEN NAME Rose Conato					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT William J Sapp		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pneumonia - Respiratory failure				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Quadraplegia (C) Metastatic Carcinoma				2 weeks 8 m	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 4-10-70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Dx		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-7-71 to 4-13-71 that (I) (we) last saw the deceased alive on 4-12-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul R. S. M.D.						DEGREE		23B. DATE SIGNED 4-13-71	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS Univ of Md Hospital			
24A. BURIAL CREMATION REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
APR 19 1971				Rabbi E. Fisher, M.D.		Frank H. Newell, Baltimore			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-445 71 3726		BALTIMORE CITY HEALTH DEPARTMENT		X	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. 71 3726	
1. NAME OF DECEASED (Type or Print) Wilhelm, IRMA - E.		2. DATE AND HOUR OF DEATH 4/13/71 1237 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY Maryland B. 110. 5300			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 806 Olmstead Rd.			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/24	9. AGE (In years last birthday) 46	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child-tourwife		10B. KIND OF BUSINESS OR INDUSTRY Md. Personality		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME John Koehne		14. MOTHER'S MAIDEN NAME Lorraine Pfeiffer	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 220-12-8403		17. INFORMANT admission record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 174 X I Respiratory insufficiency 3 wks		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic carcinoma @ Breast 4 months		(B) DUE TO, OR AS A CONSEQUENCE OF: Carcerena @ Breast 1 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Brancherexy				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/13/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory distress		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 4/11 1971 to 4/13 1971 that (I) (we) last saw the deceased alive on 4/13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick R. Eilber M.D.		23B. DATE SIGNED 4/13/71		23C. PHYSICIAN'S NAME (Type) Frederick R. Eilber M.D.	
23D. ADDRESS Maryland General Hospital					
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE April 17, 1971		24C. NAME OF CEMETERY OR CREMATORY Pikeville Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikeville Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR John E. Eilber, Jr.		25C. FUNERAL DIRECTOR Frank H. Newell, Inc.	

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

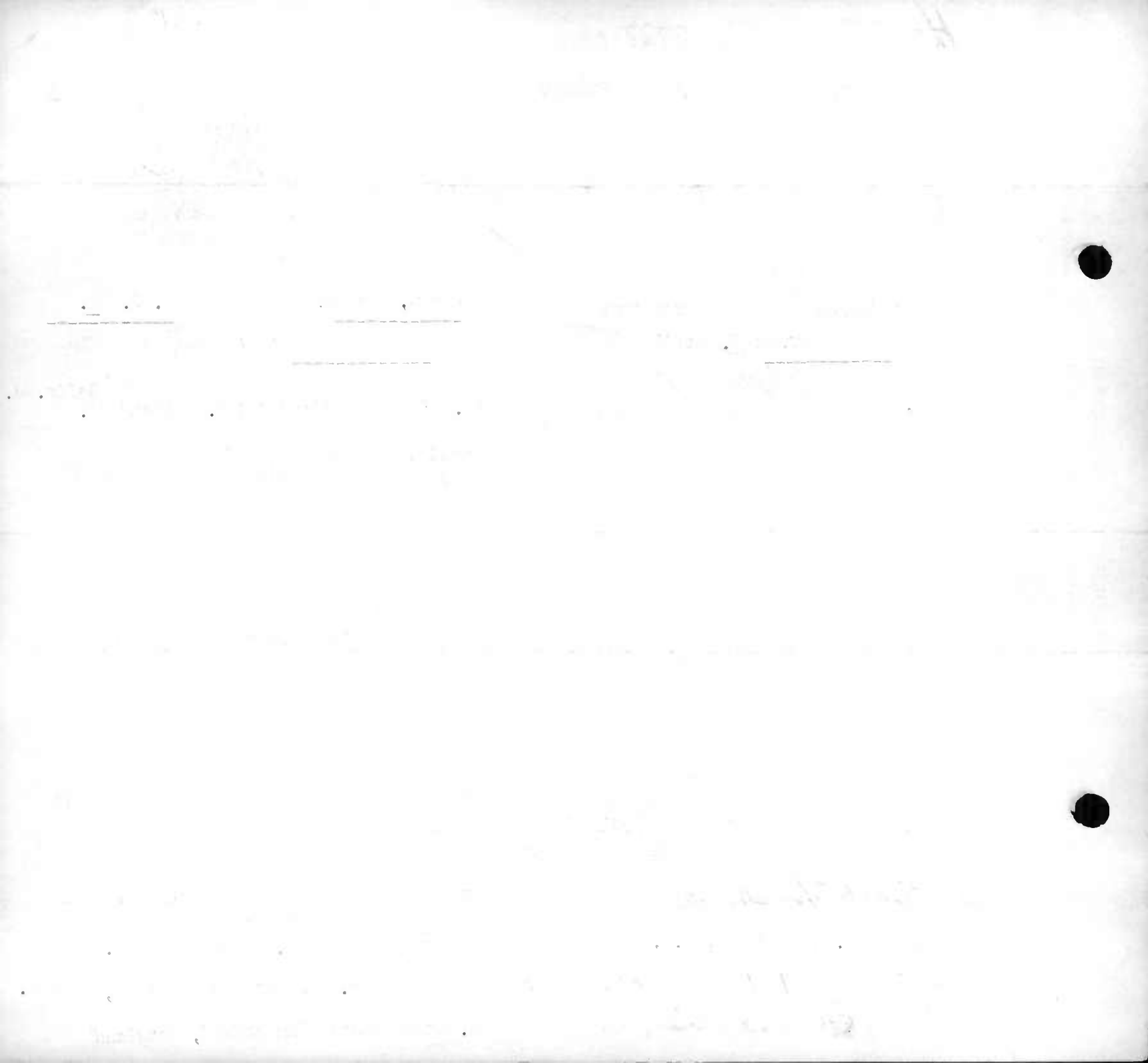
100-100-100

100-100-100

100-100-100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3727		REG. NO. 71 3727	
H-635				71 3727			
BIRTH NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) HARDIN - CHARLES FORREST				2. DATE AND HOUR OF DEATH 4-10-71 12 40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 HARBOR VIEW NURSING CENTER				A. STATE PARK B. COUNTY PARK			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 202 - S. PATTERSON ST.				F. CITY OR TOWN BALTIMORE			
5. SEX M		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-23-02	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 68		10. IF Under 1 Yr. Months: Days: Hours: Min.		11. IF Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) News Vendor				10B. KIND OF BUSINESS OR INDUSTRY Newspaper			
11. BIRTHPLACE (State or foreign country) Moscow, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles F. Hardin				14. MOTHER'S MAIDEN NAME Lillian McAbee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-58-6505			
17. INFORMANT Mrs. Mildred Wolford				ADDRESS Balto. Md. 908 S. Belnord St.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of Prostate with Pulmonary Metastasis				Year			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Malnutrition Sacral Decubitus Ulcer				Months			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XX (this hospital) attended the deceased from March 23 19 71 to April 10 19 71 that XX (we) last saw the deceased alive on April 10 19 71 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) not view the body after death.							
23A. SIGNATURE Peter H. Rheinstein, M.D.				23B. DATE SIGNED April 11, 1971			
23C. PHYSICIAN'S NAME (Type) Peter H. Rheinstein, M.D.				23D. ADDRESS Harbor View Nursing Center 1213 Light St., Baltimore, Md. 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/71		24C. NAME of CEMETERY or CREMATORY Temple Cemetery		24D. LOCATION (City, town, or county) (State) Nr. Wellersburg Somerset, Penna.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Kelley, M.D.		25C. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160		71 3728		BALTIMORE CITY HEALTH DEPARTMENT		X		71 3728	
BIRTH NO.		71 3728		CERTIFICATE OF DEATH		REG. NO.		71 3728	
1. NAME OF DECEASED (Type or Print) PAUL SCHAFFER				2. DATE AND HOUR OF DEATH 4/13/71 9:00 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD., MANCHESTER 5600 B. COUNTY CARROLL C. CITY OR TOWN MANCHESTER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 21413 LINBORO RD.					
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/47		9. AGE (In years lost birthday) 23	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Random House		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ALVIN C. SCHAFFER				14. MOTHER'S MAIDEN NAME ETHEL MERRIMAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army Res.		16. SOCIAL SECURITY NO. 220-48-3033		17. INFORMANT WIFE		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E816.2 CAUSE OF DEATH Cranio-cerebral trauma in (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ① paint depressed skull fr. ② epidural hematoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19. CAUSE OF DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E816.2 CAUSE OF DEATH Cranio-cerebral trauma in (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ① paint depressed skull fr. ② epidural hematoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office-bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Kearney Rd 570' E. of Old Hanover Rd		21D. HOW DID INJURY OCCUR? operating cycle - hit 3 times			
21E. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 4-9-71 2:30p.		21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/9/71 to 4/13/71		22. I certify that (I) (this hospital) attended the deceased from 4/9/71 to 4/13/71		22. I certify that (I) (this hospital) attended the deceased from 4/9/71 to 4/13/71		22. I certify that (I) (this hospital) attended the deceased from 4/9/71 to 4/13/71			
23A. SIGNATURE Charles J. Lancelotta M.D.		23B. DATE SIGNED 4/13/71		23C. PHYSICIAN'S NAME (Type) CHARLES J. LANCELOTTA M.D.		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-71		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Hampstead RD Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert A. Taylor, R.D.		25C. FUNERAL DIRECTOR Tipton-Eline Funeral Home		25D. ADDRESS Hampstead, Md.			

Tipton-Eline Funeral Home
Hampstead, Md.
Md.
Hampstead
Greenmount Cemetery
Burial 4-16-71

Yes

Yes Army Res. 220-48-3033

Electric Maintenance Random House USA

University Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-300 71 3728		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3728	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lucinda Foote		2. DATE AND HOUR OF DEATH 4-16-71 6:05 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 2600 Liberty Heights Ave. Baltimore, Maryland 21215		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1510		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		8. DATE OF BIRTH 5-28-1872 9. AGE (In years last birthday) 98 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME Phillip Bell		14. MOTHER'S MAIDEN NAME Tilman		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-54-6752		17. INFORMANT Mrs. Esther Patten-niece ADDRESS SAME	
18. 4/12/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory Arrest		18. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 8, 1971 to April 16, 1971 that (1) (we) last saw the deceased alive on April 16, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Spelia G. Foote M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-16-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. 2600 Liberty Heights Ave. Balto., Md. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/21/71		24C. NAME of CEMETERY or CREMATORY Mt. Zion	
24D. LOCATION (City, town, or county) (State) Longview, Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 19 1971			
25B. NAME OF REGISTRAR John E. Kelly, Jr.		25C. FUNERAL DIRECTOR Wm. J. Chatman, Jr. ADDRESS 1701 Mt. Cuthbert St. Balto. Md.			

Residence: 1011 N. 1st St.
Wichita, Kansas 67202

1011 N. 1st St.
Wichita, Kansas 67202

Wichita, Kansas

1011 N. 1st St.

X

1011 N. 1st St.

1011 N. 1st St.

Wichita, Kansas

Wichita, Kansas

1011 N. 1st St.

1011 N. 1st St.

Wichita

1011 N. 1st St.

1011 N. 1st St.

Wichita

1011 N. 1st St.

1011 N. 1st St.

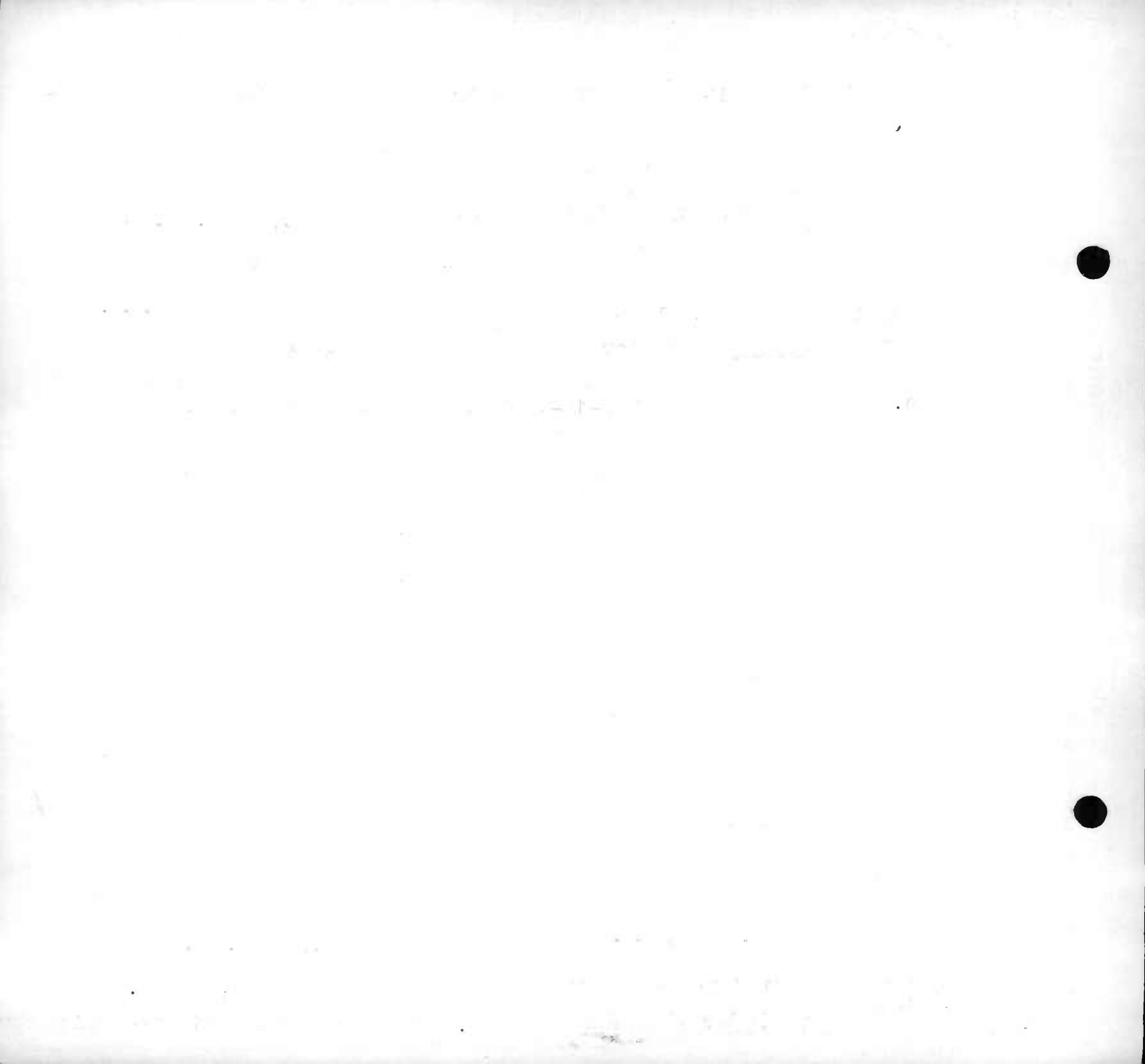
1011 N. 1st St.

1011 N. 1st St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

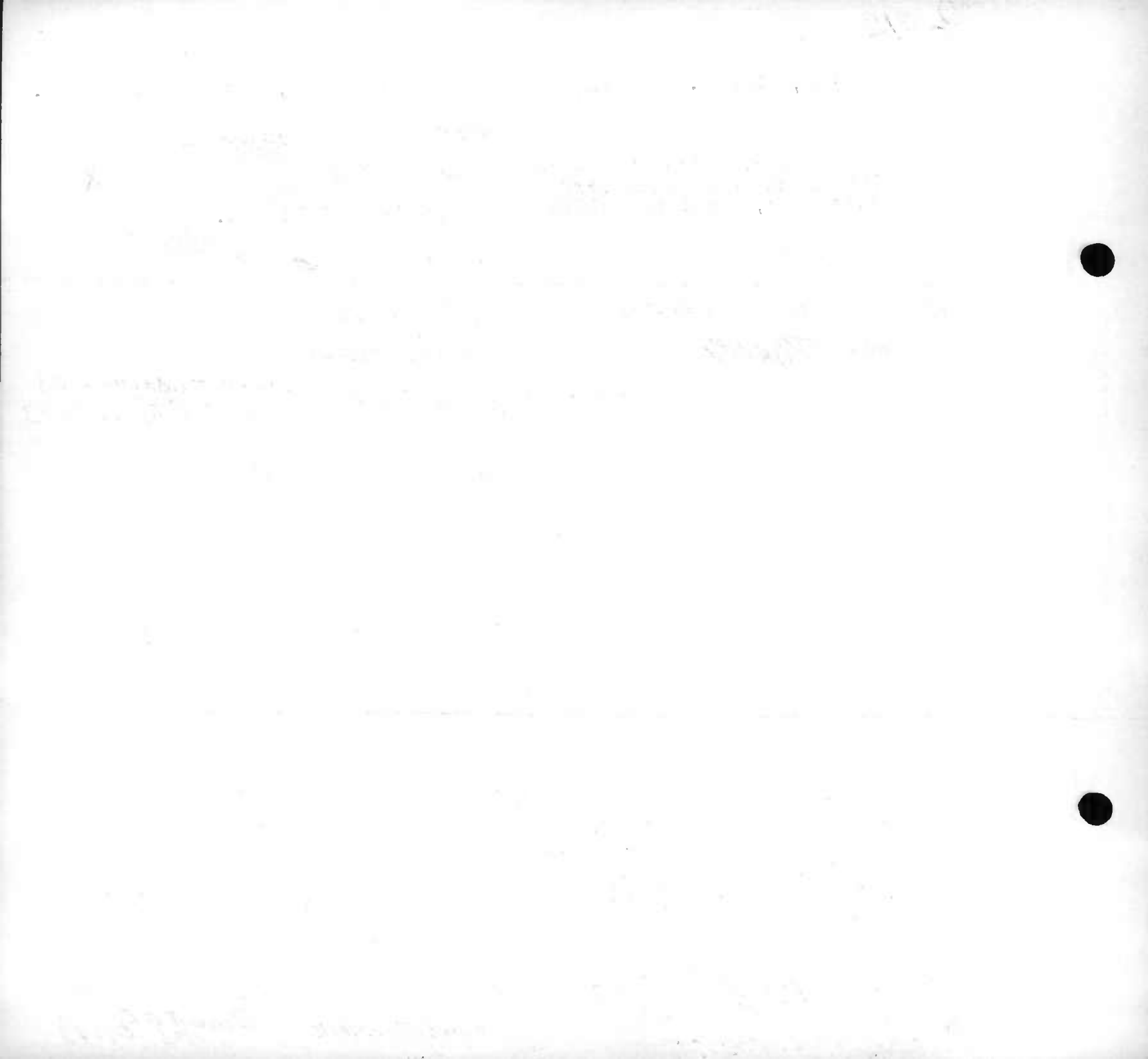
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3730	
W-236 71 3730		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Carroll D. Wachter Sr.</u>		2. DATE AND HOUR OF DEATH <u>4/13-71</u> <u>1</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2008</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>		8. DATE OF BIRTH <u>12-12-00</u> 9. AGE (in years last birthday) <u>70</u>	
13. FATHER'S NAME <u>Charles</u> <u>Wachter</u>		14. MOTHER'S MAIDEN NAME <u>Albina Koontz</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>705-10-4503</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH Records: Baltimore, Md. 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Arrest</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple Myeloma</u> (C) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> 19 <u>71</u> to <u>4/13</u> 19 <u>71</u>		and that (I) (we) last saw the deceased alive on <u>4/13</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jack D. McEue</u>		23B. DATE SIGNED <u>4/13/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Jack D. McEue, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/16/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Green Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Waynesboro, Penna.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>G. Truman Schwab</u>	
25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		25D. ADDRESS <u>3512 Frederick Ave.</u>		25E. ADDRESS <u>3512 Frederick Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

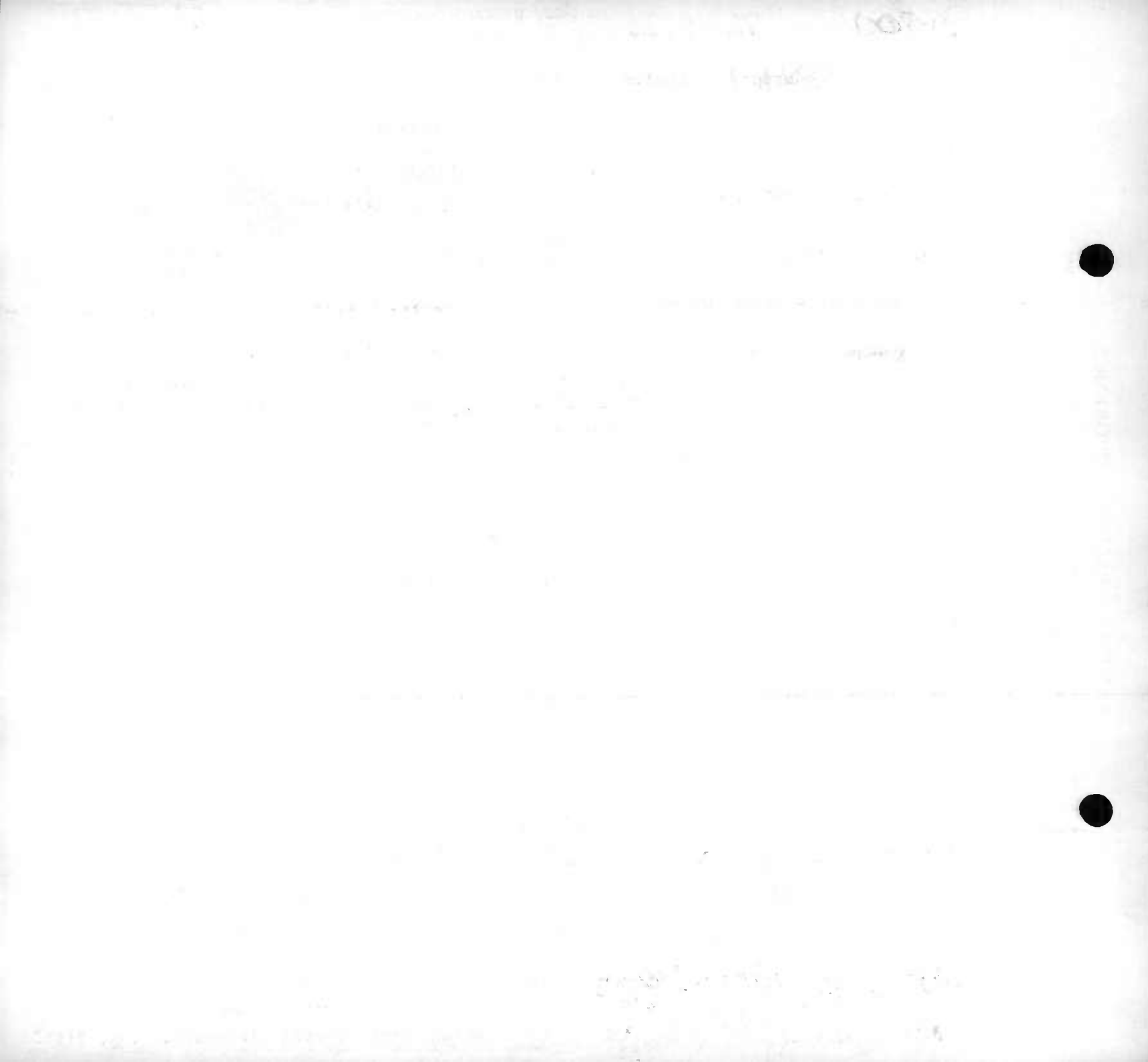
Baltimore City Health Department				REG. NO. 71 3731	
P-412 71 3731		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Phelps, Olan P. Sr.		2. DATE AND HOUR OF DEATH April 13, 1971 11:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Howard		C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION The Good Samaritan Hospital 45 5601 Loch Raven Boulevard Baltimore, Maryland 21239		E. STREET AND NUMBER 13555 Triadelphia Rd.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/19/03	9. AGE (in years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK REPAIR		10B. KIND OF BUSINESS OR INDUSTRY GENERAL		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Louis PHELPS		14. MOTHER'S MAIDEN NAME Rosalie Nichols	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219321056A		17. INFORMANT LOUISE PHELPS 13555 Triadelphia Rd Ellicott City, Md 21043	
18. 4/10/71		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction		2 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF:		15 YRS.	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Chronic Obstructive Pulmonary Disease		15 YRS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/12/71 19 to 4/13/71 19 that (1) (we) last saw the deceased alive on 4/13/71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul J. Edgar, M.D.		23B. DATE SIGNED 4/13/71		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS Good Samaritan Hospital Balto, Md.		23E. FUNERAL DIRECTOR Higinbotham-Slack		23F. ADDRESS Ellicott City, Md 21043	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-71		24C. NAME OF CEMETERY or CREMATORY ST LOUIS CEM.	
24D. LOCATION Pleasantville		24E. CITY, TOWN, or COUNTY Md.		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR J. Edgar		25C. FUNERAL DIRECTOR Higinbotham-Slack	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

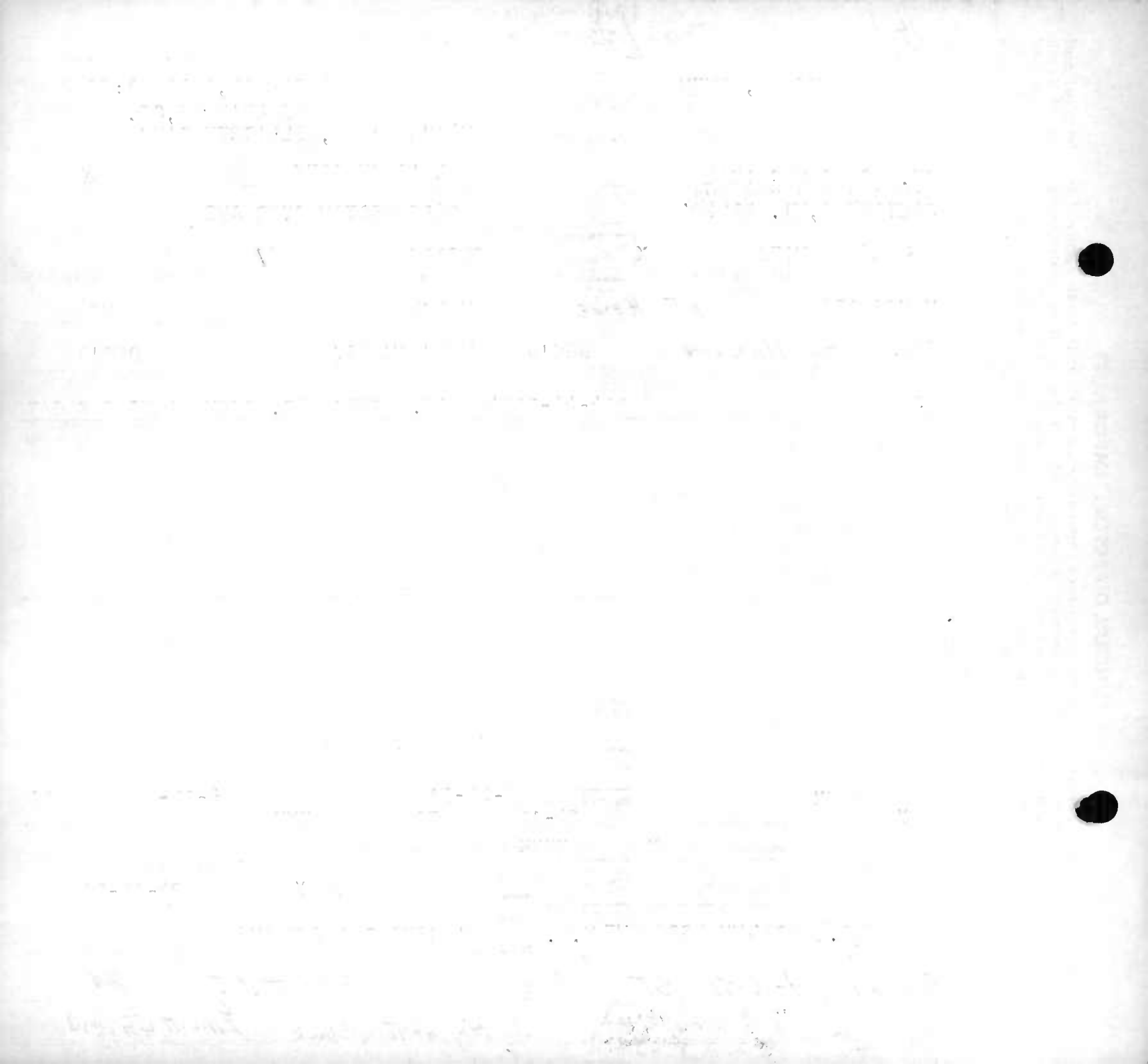
Baltimore City Health Department				71 3732	
D-500				71 3732	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Gordon Phelps Dean			4/14/71 10:37 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 7 Mercy Hospital			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY Baltimore		
			C. CITY OR TOWN Milford Gardens		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 3505 Mayfair Road 21207		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1909	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant - Sinai		10B. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George Davis Dean			14. MOTHER'S MAIDEN NAME Eva Viola (Phelps)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 215-07-5455	17. INFORMANT Mrs. Frances Dean 3505 Mayfair Road Baltimore, Md. 21207		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Uremia DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic CHF					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/23/1971 to 4/14/1971 that (I) (we) lost saw the deceased alive on 4/14/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lwin			23B. DATE SIGNED 4/14/71		23C. PHYSICIAN'S NAME (Type) KYI KYI LWIN MD
23D. ADDRESS Mercy Hospital			23E. DATE REC'D BY HEALTH DEPT. APR 18 1971		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/17/71		
24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery			24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland		
25A. NAME OF REGISTRAR Loring Byers			25B. FUNERAL DIRECTOR 8728 Liberty Road		
25C. ADDRESS Loring Byers Funeral Directors, P. A. 21133			25D. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-140 BIRTH NO.		71 3733		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 3733	
1. NAME OF DECEASED (Type or Print) UEBEL, RUTH				2. DATE AND HOUR OF DEATH APRIL 12, 1971 3:05 P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21229.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE, MD. C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2630 WESTCHESTER AVE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 020110	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT Home			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK B. HAMSON DEC 'D			14. MOTHER'S MAIDEN NAME MARY CHANEY DEC 'D						
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214-44-7294		17. INFORMANT ST. AGNES REC. ROOM WILKENS & CATON				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Liver failure & renal failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post operation for intestinal obstruction (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 3-29-71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Transverse Colostomy			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 2-27-71 to 04-12-71 that (X) (we) last saw the deceased alive on 04-12-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. J. Muangsombut MD DEGREE						23B. DATE SIGNED 04-12-71		23C. PHYSICIAN'S NAME (Type) DR. JESDA MUANGSOMBUT M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-16-71		24C. NAME OF CEMETERY OR CREMATORY ST Johns		24D. LOCATION (City, town, or county) (State) Ellicott City MD		
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971			25B. NAME OF REGISTRAR J. J. Muangsombut MD			25C. FUNERAL DIRECTOR Higginbotham Slack ADDRESS Ellicott City MD.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)WILLIAM A. ~~HEALEY~~ HEALEY2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 16, 1971

11:35 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

401

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7/31/1900

10. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

423 W. Saratoga Street

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF
WHAT COUNTRY?

Ind.

13. FATHER'S NAME

Patrick Healey

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Nurse

14B. KIND OF BUSINESS OR INDUSTRY

Hotel

15. MOTHER'S MAIDEN NAME

Dorothy Kearney

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

✓

18. INFORMANT

Francis B. Healey - 261 Arundel Rd. 21122

ADDRESS (Residence Ind.)

19. 4124

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/16/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/19/71

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1971

25B. NAME OF REGISTRAR

Robert E. Jones

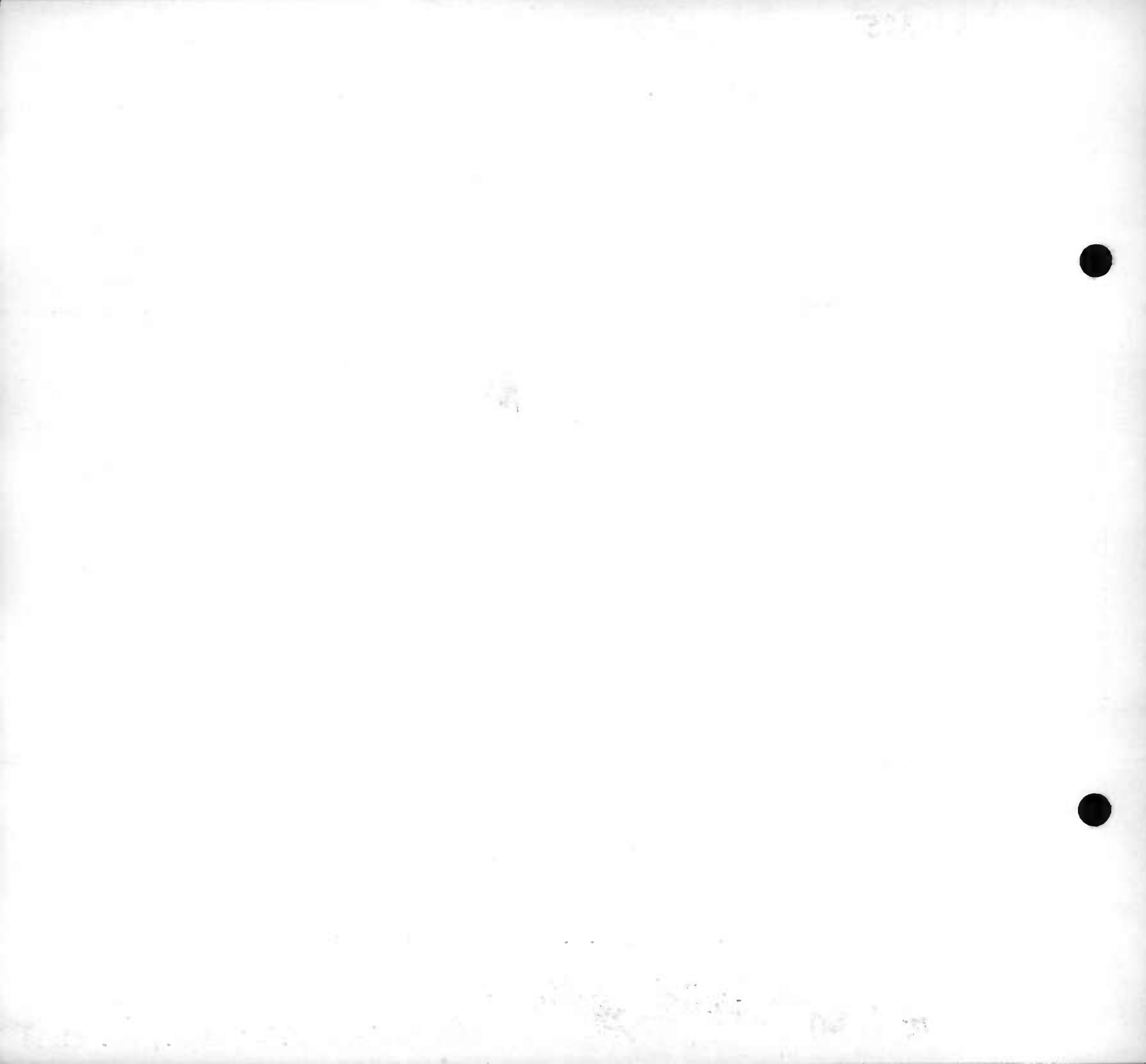
25C. FUNERAL DIRECTOR

John P. Corwin, Sr. 901 Hollins St. Balt. Md. 21223

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3735</u>	
J-325 71 3735		CERTIFICATE OF DEATH	
BIRTH NO. <u>Judson, Otto E</u>		2. DATE AND HOUR OF DEATH <u>4-14-71</u> <u>6¹⁰ P M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Judson, Otto E.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2716</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>9 Keswick Home</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3410 Dupont Ave</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1890</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>80</u>
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel P Judson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Gulikson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>817-03-8531</u>	
17. INFORMANT <u>Keswick Records</u>		ADDRESS <u>700 W. 40th St</u>	
18. <u>470.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic CVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>30 Mar</u> 19 <u>71</u> to <u>14 April</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>14 April</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Harold P. Biehl</u>		23B. DATE SIGNED <u>4/14/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harold P. Biehl, M.D.</u>		23D. ADDRESS <u>Keswick Nursing Home</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/16/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25C. FUNERAL DIRECTOR <u>Robert C. Altenburg</u>	
25B. NAME OF FUNERAL HOME <u>Robert C. Altenburg Funeral Home Inc</u>		ADDRESS <u>6009 Harford Rd. - Balto., Md. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3736	
C-000 BIRTH NO. 1. NAME OF DECEASED (Type or Print) LLOYD COE		2. DATE AND HOUR OF DEATH 4/16/71 8:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Carroll C. CITY OR TOWN Taneytown D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER R.F.D.# 1m			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/99 9. AGE (in years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph S. Coe			
14. MOTHER'S MAIDEN NAME Carrie C. Harman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lloyd Bollinger, Taneytown, Maryland 21787			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days hrs	
(A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:				(B) INTESTINAL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF:	
(C) ASCVD					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/15 19 71 to 4/16 19 71 that (we) last saw the deceased alive on 4/16 19 71 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alberto Barbedo, M.D.				23B. DATE SIGNED 4/16/71	
23C. PHYSICIAN'S NAME (Type) ALBERTO BARBEDO, M.D.				23D. ADDRESS SINAI HOSP. of BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/71		24C. NAME OF CEMETERY OR CREMATORY Baust Cemetery	
24D. LOCATION (City, town, or county) (State) Taneytown, Carroll Co., Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971				25C. FUNERAL DIRECTOR ADDRESS C.O. Fuss & Son Taneytown, Maryland	

100-100-1

UNITED STATES
DEPARTMENT OF JUSTICE

W M

UNITED STATES

DEPARTMENT OF JUSTICE

UNITED STATES

UNITED STATES

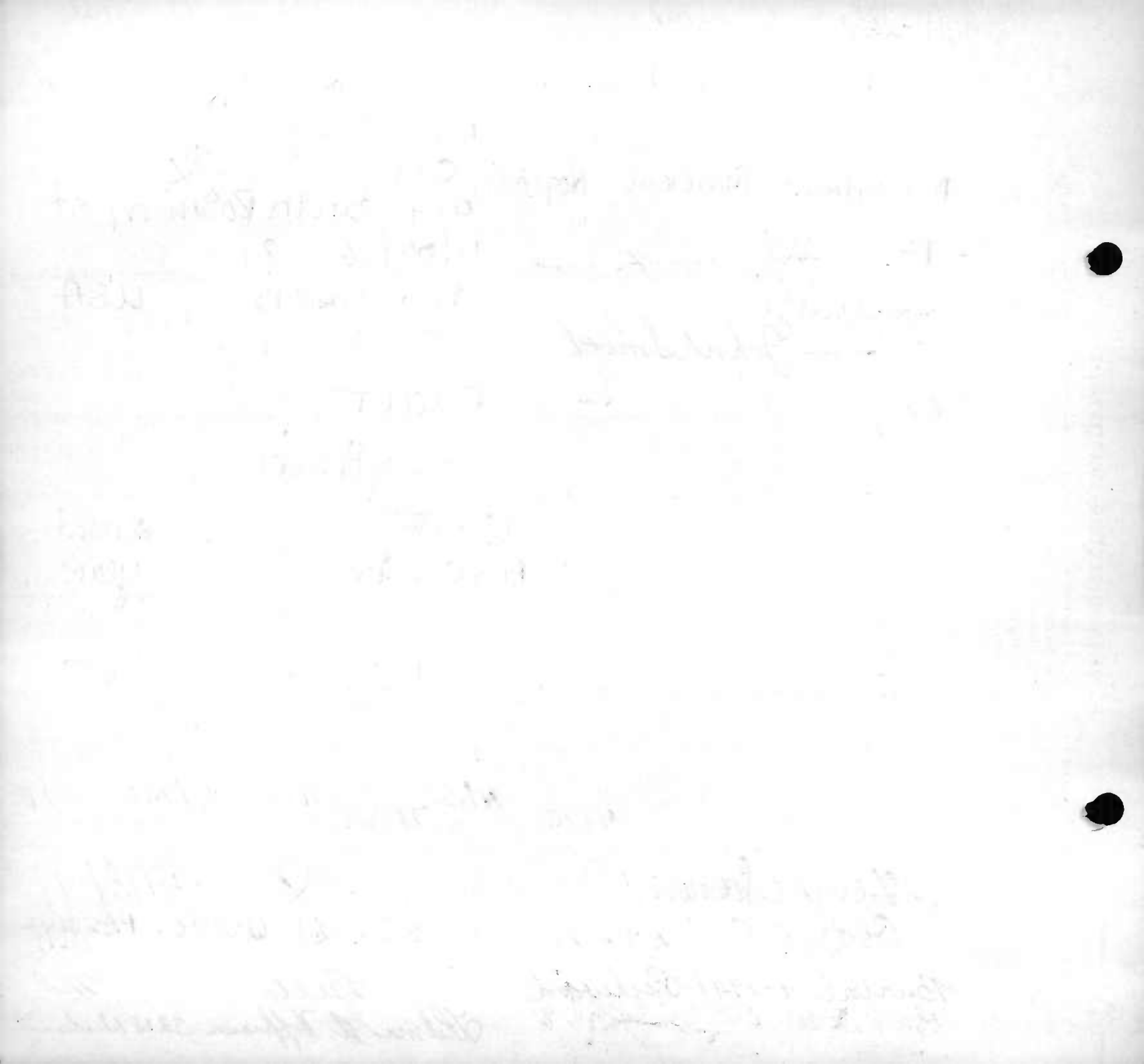
UNITED STATES

UNITED STATES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

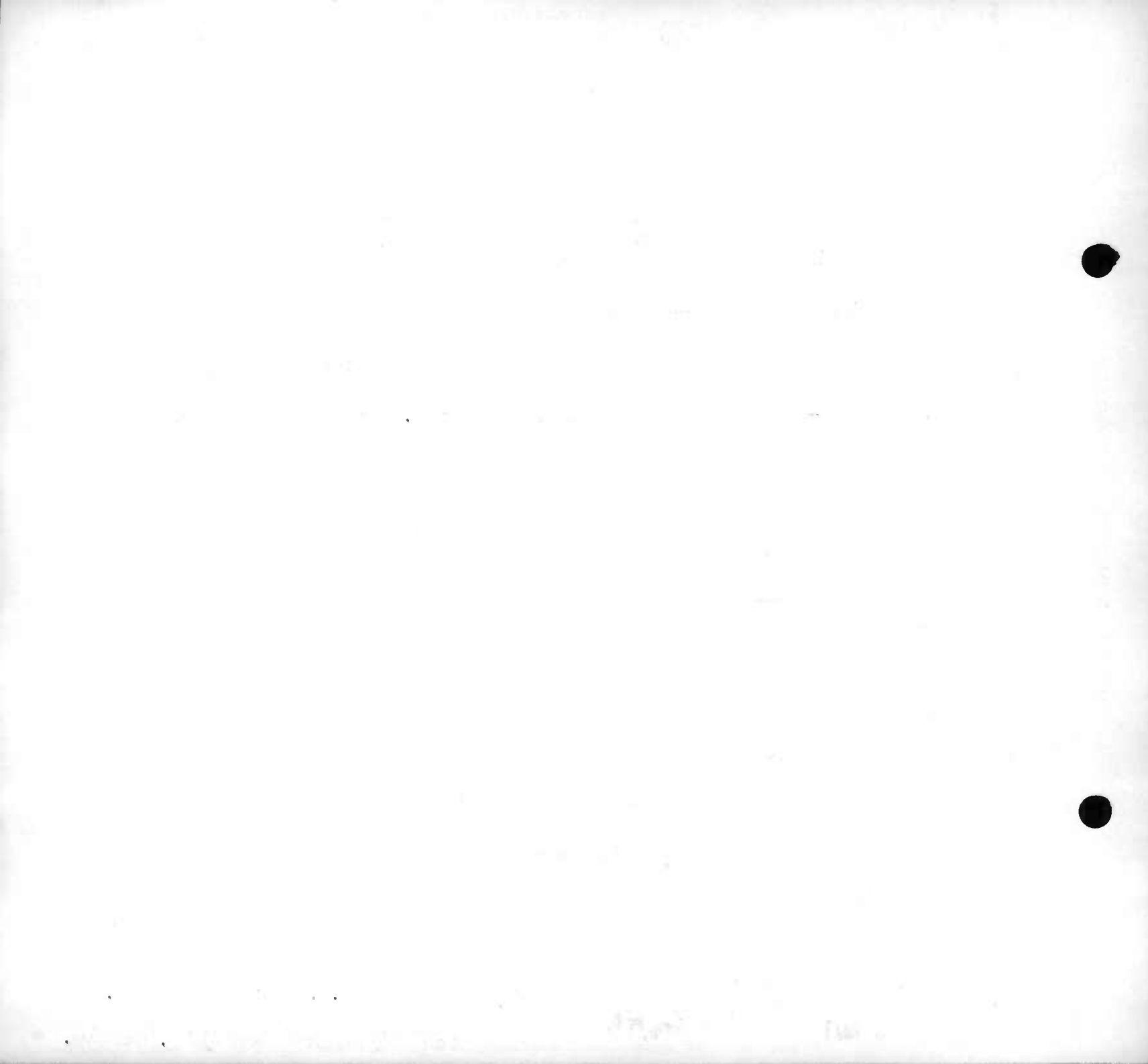
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 11 3737									
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		Mrs. Annie MARSER				2. DATE AND HOUR OF DEATH 4/15/71 2:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MD. City 102			
						C. CITY OR TOWN CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER 414 South Robinson St.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/07/76		9. AGE (In years last birthday) 94		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Chant			
18. 4/12/41				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: anaphylaxis					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: CHF				2 months	
				(C) ASCVD				years	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/12 1971 to 4/15 1971, that (I) (we) last saw the deceased alive on 4/15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE George C. Sammons						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/15/71	
23C. PHYSICIAN'S NAME (Type) George C. Sammons						23D. ADDRESS 45 Bayside Drive Pasadena MD.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 4-19-71		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971				25B. NAME OF REGISTRAR George C. Sammons		25C. FUNERAL DIRECTOR Thelma D. Hoffmann			
						ADDRESS 3218 N. Hudson St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

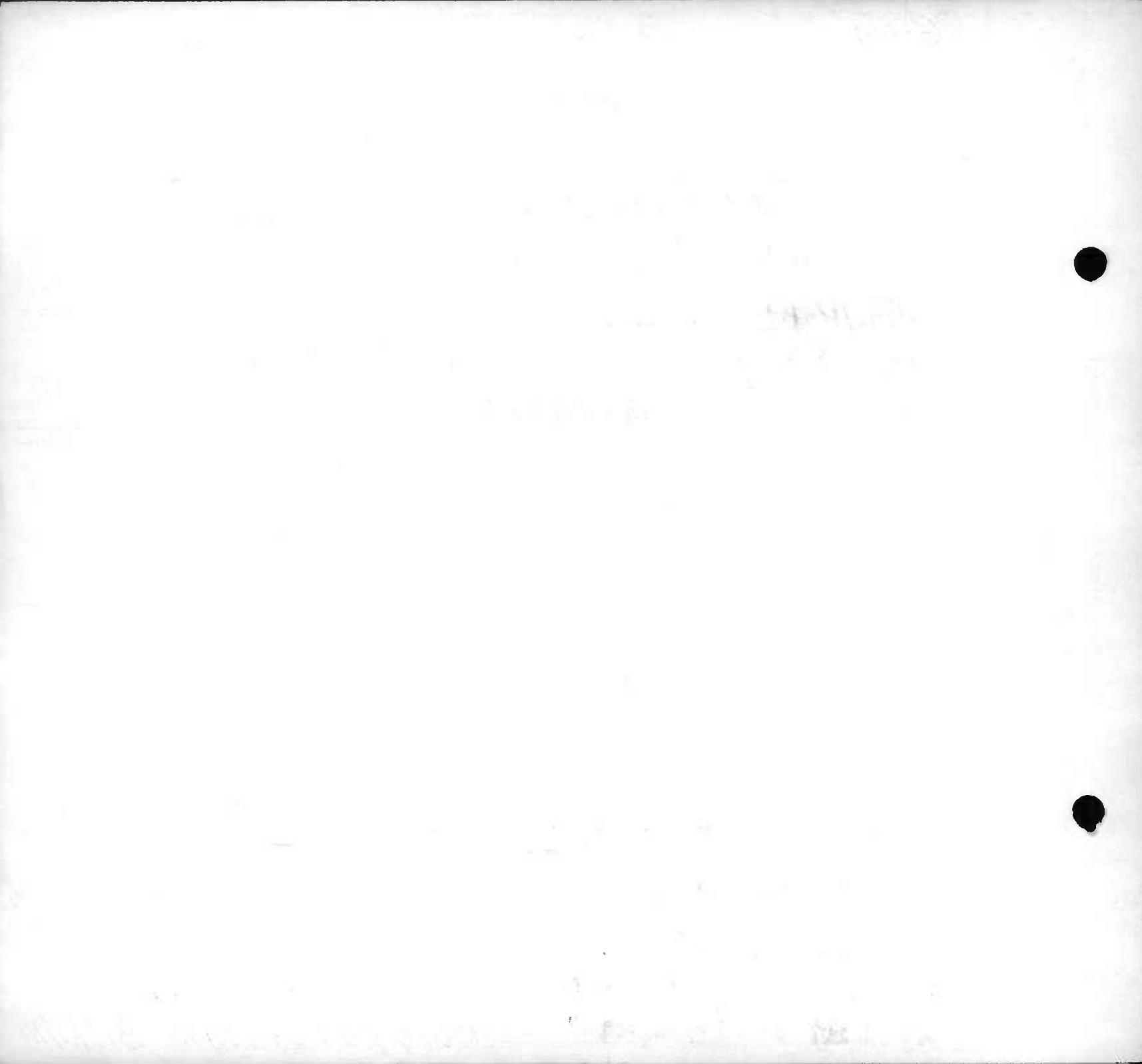
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3738	
C-140 71 3738		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Glenn Cuffley</i>		4/15/71 15:10 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>3001 S. Hanover St. Balto. Md.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>2403</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1004 Compton St</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/6/39</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. AGE (In years last birthday) <i>32</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>	
13. FATHER'S NAME <i>Roy Collins</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
14. MOTHER'S MAIDEN NAME <i>Dora Bucklewelk Chadwell</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Reva J. Mason</i>	
		ADDRESS <i>1004 Compton Street</i>	
18. <i>571.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Lacemec Cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic Alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/14</i> 19 <i>71</i> to <i>4/15</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4/15</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.			
23A. SIGNATURE <i>David Silverman M.D.</i>			23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <i>D. Silverman</i>			23D. ADDRESS <i>South Balto. Gen. Hospital</i>
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>4/19/71</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>A.A. County Md.</i>
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971	25B. NAME OF REGISTRAR <i>James E. Miller, M.D.</i>	25C. FUNERAL DIRECTOR <i>Mc Gully Funeral Home 130 E. Fort Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

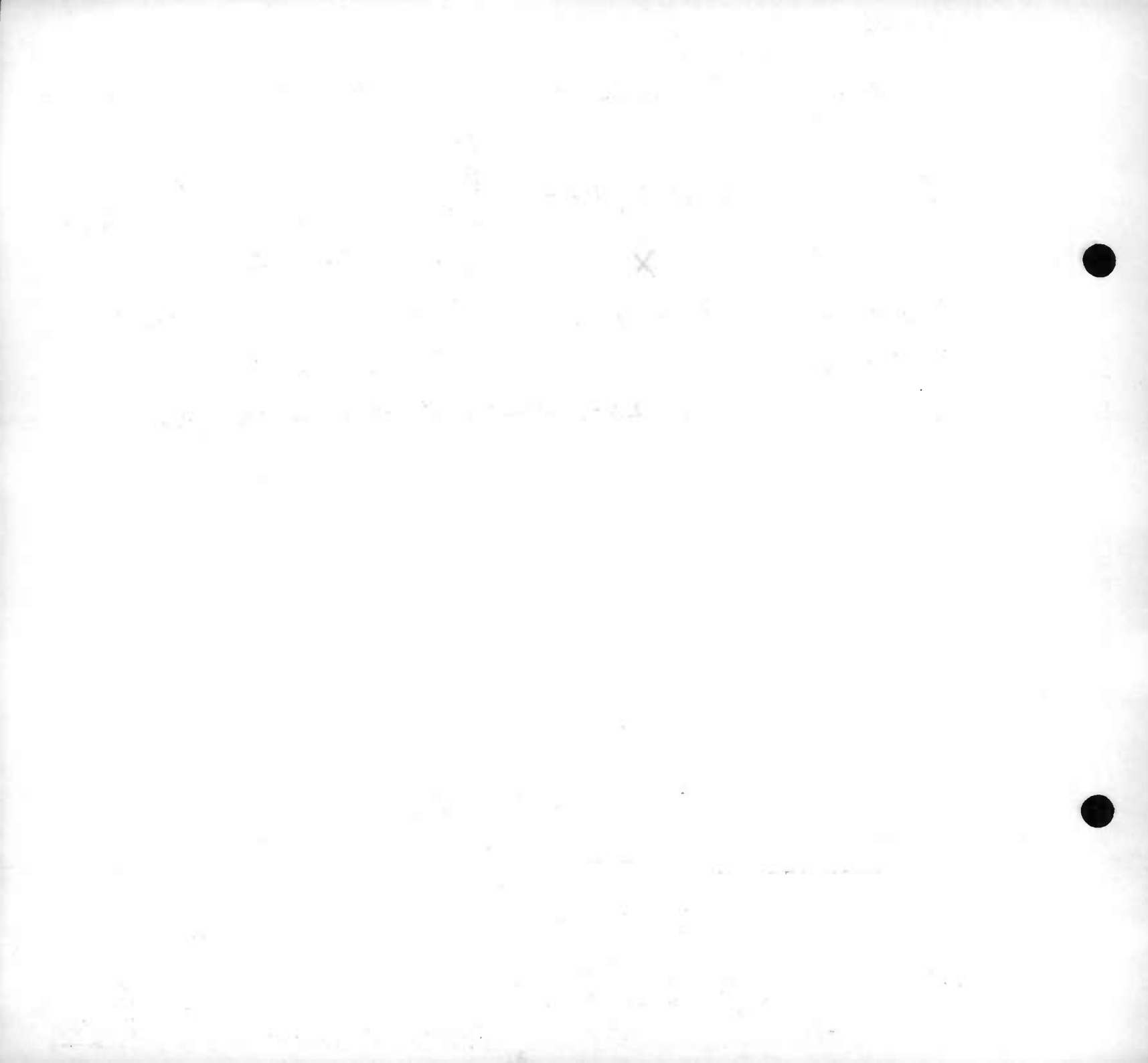
G-600 71 3739				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3739	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GARY, O THELLO L.				2. DATE AND HOUR OF DEATH 13 April 1971		5:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1348			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital 33 rd and Calvert streets Baltimore Md 21218				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1324 Delwood Avenue Baltimore			
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 05/28/08		9. AGE (in years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Joseph S Gary				14. MOTHER'S MAIDEN NAME Carrie V Brice			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213104717		17. INFORMANT Medical records Union Memorial Hospital 33 rd and Calvert			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory arrest.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. metastatic Carcinoma.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) due to Carcinoma of the upper lobe of lung			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 27 August 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED malignant tumor left lung		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/26/1971 to 4/13/1971 that (I) (we) last saw the deceased alive on 4/13/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fatih Salih Zada, M.D.				23B. DATE SIGNED 13 April 71, 5:40 AM			
23C. PHYSICIAN'S NAME (Type) FATIH SALIH ZADA, M.D.				23D. ADDRESS Union Memorial Hospital, 33 rd and Calvert streets Baltimore Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 16 Apr 71		24C. NAME of CEMETERY or CREMATORY Ebenezer Cem		24D. LOCATION (City, town, or county) (State) Carroll Co Md	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS Baltimore Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
71 3740 CERTIFICATE OF DEATH					REG. NO. 71 3740						
BIRTH NO. <u>B-622</u>					1. NAME OF DECEASED (Type or Print) <u>BURGESS - FRANCIS P</u>						
2. DATE AND HOUR OF DEATH <u>4-9-71 12:30 A.M.</u>					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>BON SECOURS HOSPITAL</u>						
4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2002</u>					5. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
6. STREET AND NUMBER <u>2460 WEST BALTIMORE ST.</u>					FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON SECOURS HOSPITAL</u>						
7. SEX <u>M</u>		8. RACE <u>W.</u>		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH <u>3-8-85</u>		11. AGE (In years last birthday) <u>86</u>			
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		13. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		14. BIRTHPLACE (State or foreign country) <u>Md.</u>		15. CITIZEN OF WHAT COUNTRY? <u>USA</u>		16. FATHER'S NAME <u>Unknown</u>			
17. MOTHER'S MAIDEN NAME <u>Mary C Belt</u>		18. Was Deceased Ever in U.S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) <u>No</u>		19. SOCIAL SECURITY NO. <u>212-18-5220</u>		20. INFORMANT <u>Raymond W Burgess</u>		21. ADDRESS			
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic ill, Malnutrition, dysphagia & Vremid & Biliary infection & Septicemia</u>					23. CAUSE OF DEATH (A) IMMEDIATE CAUSE - <u>1a (Pseudo meningitis)</u> DUE TO, OR AS A CONSEQUENCE OF: <u>as mentioned above.</u>					24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					26. DUE TO, OR AS A CONSEQUENCE OF: <u>(c) Septicemia (Pseudo meningitis) & malnutrition</u>						
27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
28. DATE OF OPERATION <u>None</u>		29. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		30. AUTOPSY? (Yes or No) <u>X</u>		31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>None</u>		33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>							
35. TIME OF INJURY (Approx.) <u>None</u>		36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		37. HOW DID INJURY OCCUR? <u>None</u>							
38. I certify that (I) (this hospital) attended the deceased from <u>4-3-71</u> 19 <u>71</u> to <u>4-9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
39. SIGNATURE <u>Ferdous KAZEMI M.D.</u>					40. DATE SIGNED <u>4-9-71</u>		41. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
42. PHYSICIAN'S NAME (Type) <u>FERDOUS KAZEMI M.D.</u>					43. ADDRESS <u>BON SECOURS Hospital, Baltimore, Md.</u>						
44. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		45. DATE <u>13 Apr 71</u>		46. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>		47. LOCATION (City, town, or county) <u>Woodlawn, Balt Md</u>		48. STATE <u>21223</u>			
49. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		50. NAME OF REGISTRAR <u>George E. ...</u>		51. FUNERAL DIRECTOR <u>George Funeral Home Balt Md</u>		52. ADDRESS					



M-230

71 3741 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 3741

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HENRIETTA M. MACATEE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 15, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3008 Bayonne Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1971 3:40 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct. 25, 1921. 49		10. AGE (In years last birthday) 49	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-12-8753	
18. INFORMANT Mrs. Henrietta Macatee		ADDRESS (Same)	
19. 412.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D.		21. AUTOPSY? (Yes or No) Yes	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/71.	
24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery		24D. LOCATION (City, town, or county) (State) Pylesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Bailey, Jr.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

Letter from M.E.'s office

5-25-71 M.H.

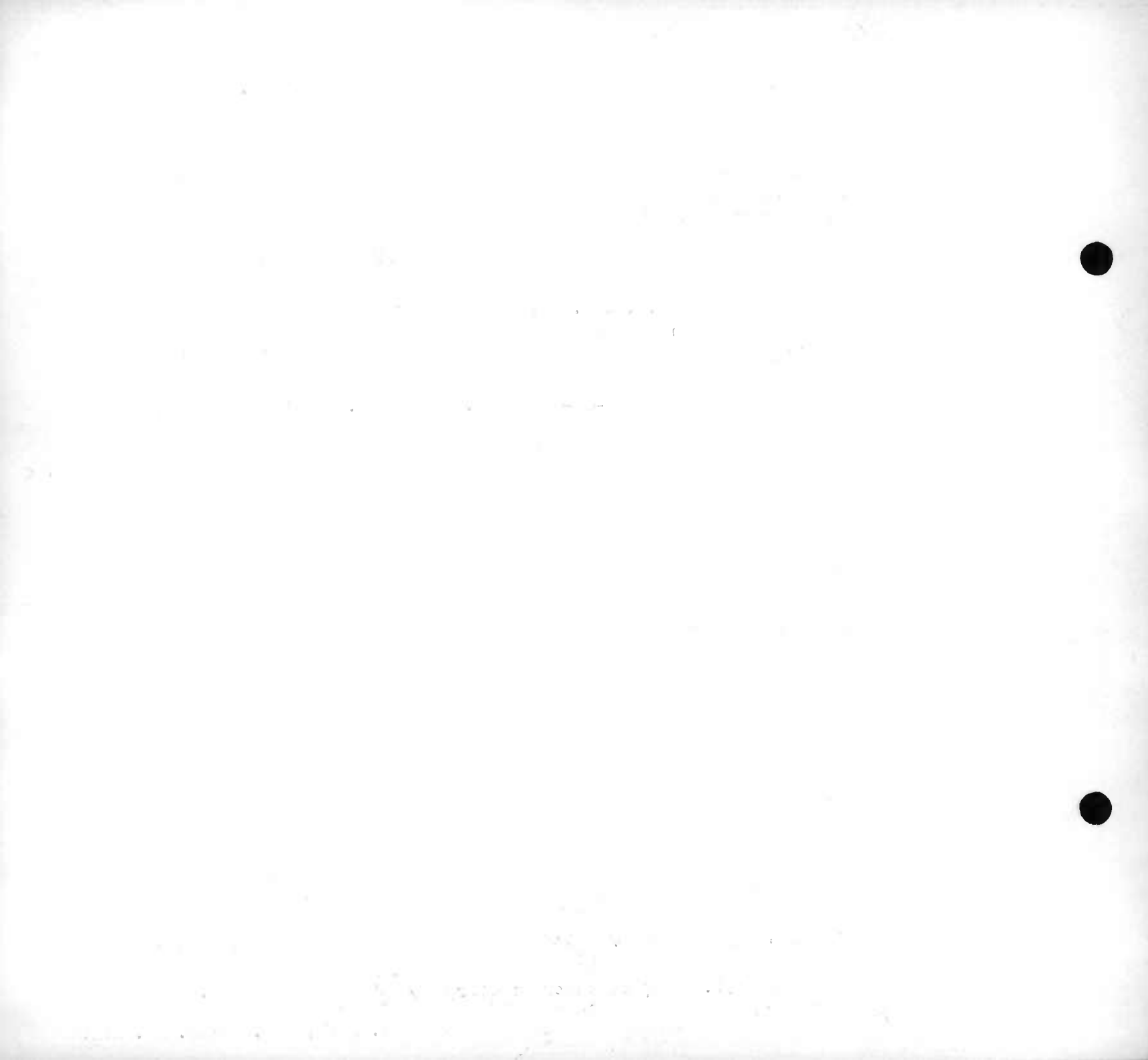
ACADEMY BOND

MADE IN U.S.A.
VAN DYKE PAPER CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3742</u>	
M-620 71 3742		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Mary Louise Morris</u>		2. DATE AND HOUR OF DEATH <u>April 14, 1971.</u> <u>6 00</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2748</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>5601 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21239</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>5642 Woodmont Avenue</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IBM Operator</u>		8. DATE OF BIRTH <u>2/07/28</u> 9. AGE (in years last birthday) <u>43</u> 45	
10B. KIND OF BUSINESS OR INDUSTRY <u>U.S.F.&G. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Attilio D'Ambrogi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Michelina Porcu</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>219-18-3388</u>		17. INFORMANT <u>Mr. Bernard S. Morris</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF BREAST, METASTATIC</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 YEARS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>Mar 8, 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>Mar 8, 1971</u> to <u>April 14, 1971</u> that <u>(H)</u> (we) last saw the deceased alive on <u>April 14, 1971</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Michael Colvin, M.D.</u>		23B. DATE SIGNED <u>April 14, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL COLVIN, M.D.</u>		23D. ADDRESS <u>Good Samaritan Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25D. ADDRESS	



E-456

71 3743

BALTIMORE CITY HEALTH DEPARTMENT

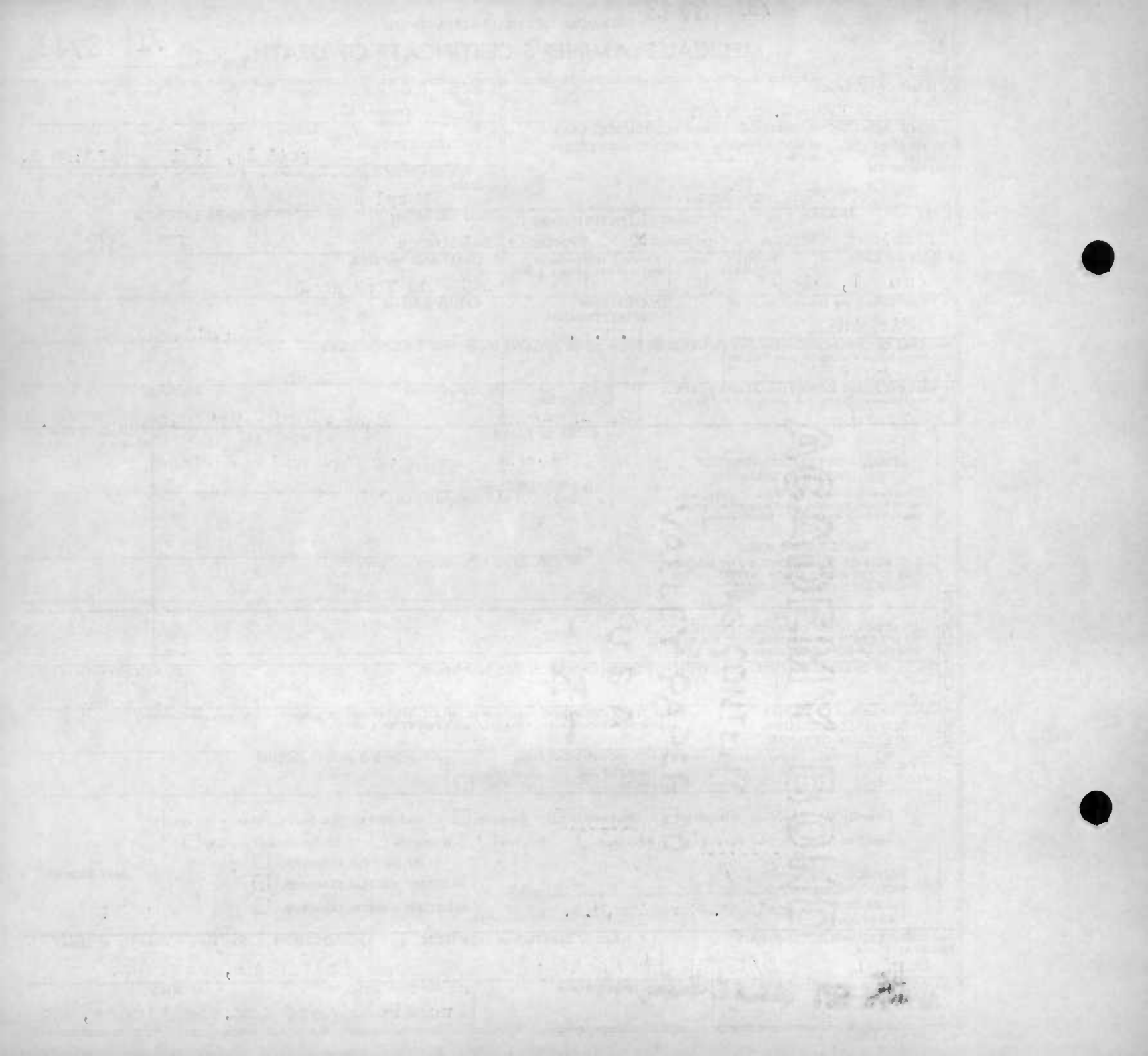
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3743

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EVA N. - ELMORE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3609 Old York Road		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1971 12:50 P.M.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 1, 1890		10. AGE (In years last birthday) 80	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 227-20-9266	
18. INFORMANT Mrs Helen Vinci		ADDRESS 3535 Alameda Cir.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/71	
24C. NAME OF CEMETERY or CREMATORY Oaklawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECD BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Leonard J Ruck Inc.	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		ADDRESS Baltimore, Md	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BARBARA TUTTLE

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

1205

6. SEX

female

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/30/1937

10. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

11 E. Lafayette Ave.

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter E. Harney

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elizabeth O'Mara

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

A.J. Lamoureux New Bedford, Mass.

19.

303.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Acute ethylism
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/14/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/20/71

24C. NAME OF CEMETERY or CREMATORY

St. Mary's Cemetery

24D. LOCATION (City, town, or county)

New Bedford, Mass.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1971

25B. NAME OF REGISTRAR

R. E. E. E. E.

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc. Balto. Md.

Letter from M.E.'s office

6-11-71 M.H.

VALLEY FORGE
VALLEY FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. <u>71 3745</u>				
BIRTH NO. <u>71 3745</u>					2. DATE AND HOUR OF DEATH <u>April 15, 1971</u> <u>3:15 A.M.</u> M.				
1. NAME OF DECEASED (Type or Print) <u>Sister Paula Gates</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>City</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>94 Villa Saint Michael</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					C. CITY OR TOWN <u>Baltimore City</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>4000 Forest Hill Road 21207</u>				
5. SEX <u>F.</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1892</u>	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher (retired)</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Sister of Charity</u>		11. BIRTHPLACE (State or foreign country) <u>Albany, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.S. U.S.A.</u>		
13. FATHER'S NAME <u>John A. Gates</u>					14. MOTHER'S MAIDEN NAME <u>Nellie King</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-54-0052-J1</u>		17. INFORMANT <u>Sister Andrea</u> ADDRESS <u>same address</u>				
18. CAUSE OF DEATH <u>4-40-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular Collapse</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>17 years (4)</u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>None</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>None</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>			
21D. TIME OF INJURY (APPROX.) <u>None</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>None</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>April, 1971</u> that (I) (we) last saw the deceased alive on <u>April 13, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.									
23A. SIGNATURE <u>Damian P. Alagia</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>April 15, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Damian P. Alagia</u>					23D. ADDRESS <u>3326 Frederick Ave., Baltimore, 21228</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>4/17/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO.</u> ADDRESS <u>108 W. North Av. 1</u>			

1911, 1912

1913, 1914

1915, 1916

1917, 1918

1919, 1920

1921

1922, 1923

1924, 1925

1926

1927, 1928

1929, 1930

1931, 1932

1933, 1934

1935, 1936

1937, 1938

1939, 1940

1941, 1942

1943, 1944

1945, 1946

1947, 1948

1949

1950, 1951

1952, 1953

1954, 1955

1956, 1957

1958, 1959

1960

1961, 1962

1963

1964, 1965

1966, 1967

1968, 1969

1970, 1971

1972, 1973

1974, 1975

1976, 1977

1978, 1979

1980, 1981

1982, 1983

1984, 1985

1986, 1987

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3746	
71 3746				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CAROLYN V. DOLLINGER		THUR APR. 15-1971 9:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 9 CHESTNUT AND HOME 2112 McCULLOCH ST.				A. STATE Md. B. COUNTY 2646	
				C. CITY OR TOWN Baltimore 21224 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6108 CARPDIFF AVE					
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27 1944	9. AGE (In years lost birthday) 29	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTH PLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CARL C. CAMERON			14. MOTHER'S MAIDEN NAME Retha E. Walters		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 217-38-3728		17. INFORMANT Mrs Retha E. Cameron (Mother) ADDRESS (Same)	
18. 2509 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Acute Coronary Occlusion 1 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus Unknown (B) DUE TO, OR AS A CONSEQUENCE OF: Mental Derangement Unknown (C) Epilepsy Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/14 1971 to 4/15 1971, that (I) (we) last saw the deceased alive on 4/15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. E. Holt M.D.				23B. DATE SIGNED 4/17/71	
23C. PHYSICIAN'S NAME (Type) E. E. Holt				23D. ADDRESS 3715 Liberty Bldg. Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE APR 19-1971		24C. NAME OF CEMETERY OR CREMATORY GLEN BURNING CEM.	
24D. LOCATION (City, town, or county) GLEN BURNING, MD.		(State)			
25A. DATE REC'D BY HEALTH DEPT APR 19 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR CURTIS E. EVANS ADDRESS 1400 S. CHARLES ST 21230	

CHARTERED BY THE AMERICAN ...

Carl E. Cameron
From ...
212 McCutcheon St.
Chestnut Third Floor

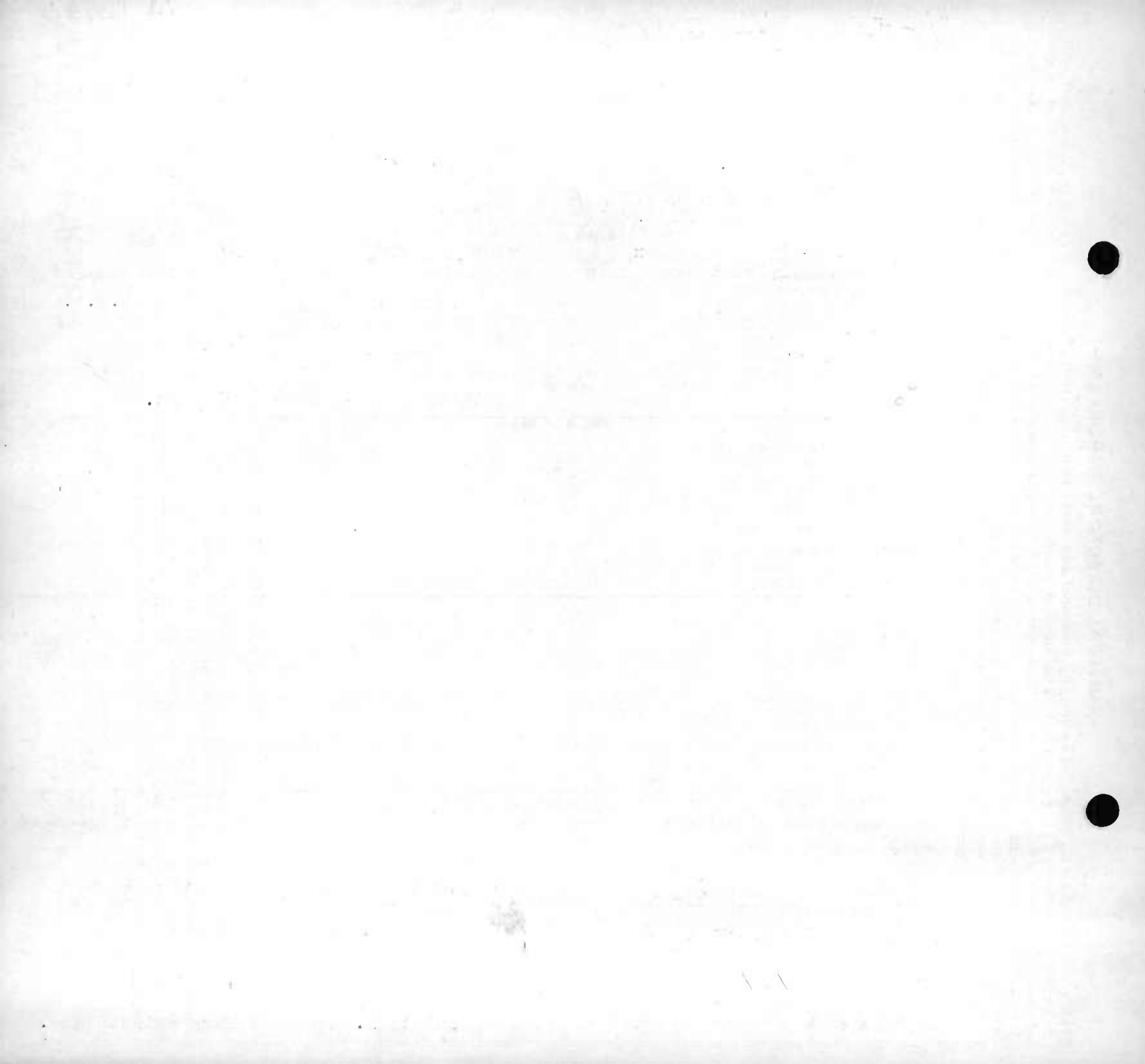
Arthur E. Cameron
From ...
212 McCutcheon St.
Chestnut Third Floor

Printed by ...
1902 ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

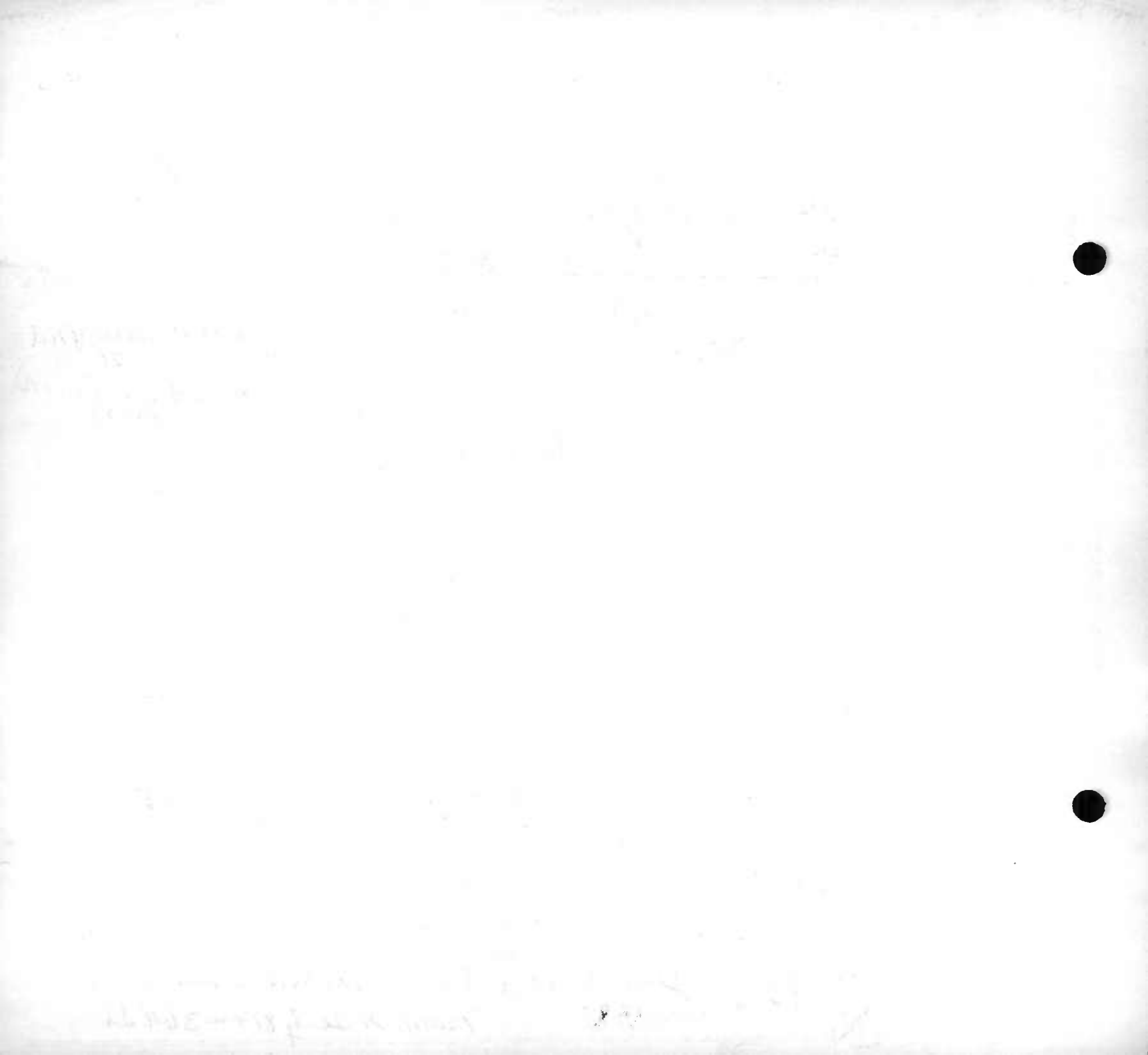
Baltimore City Health Department				REG. NO.	
N-550 71 3747		71 3747			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harriett Newman</i>		2. DATE AND HOUR OF DEATH <i>April 12 1971 12 05 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1501</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Mt Sinai Nursing Home</i> <i>4613 Park Heights Ave</i> <i>Balto Md 21215</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto</i>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1444 Parrish Street</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/2/86</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>David Walker</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>William Newman 1444 Parrish St.</i>	
18. <i>433.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral thrombosis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diffuse degenerative cerebral disease</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 dg</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Severe anemia</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 7 1971</i> to <i>April 12 1971</i> , that (I) (we) last saw the deceased alive on <i>April 12 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Raymond H. Rubin</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/10/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Raymond H. Rubin</i>		23D. ADDRESS <i>5415 Park Heights Ave</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>4/16/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Kenneth H. Law</i>	
				ADDRESS <i>4609 Park Heights Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400		71 3748		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3748	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) WALTER DALY			
2. DATE AND HOUR OF DEATH 4/15/71				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD PLEASANT MANOR NURSING HOME 904615 PARK HEIGHTS AVE			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1307				5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3802 Elm Ave				8. DATE OF BIRTH 3/13/1885 9. AGE (In years last birthday) 86			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10B. KIND OF BUSINESS OR INDUSTRY B+O R.R.			
11. BIRTHPLACE (State or foreign country) MD				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME HENRY T DALY				14. MOTHER'S MAIDEN NAME Mitchell 405 S. ROLLING RD 21			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mitchell, A. DALY				ADDRESS 405 S. ROLLING RD 21228			
18. 41231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) arteriosclerotic Heart Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: non (B) DUE TO, OR AS A CONSEQUENCE OF: non (C) DUE TO, OR AS A CONSEQUENCE OF: non			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 19 1970 to April 15 1971 that (I) (we) last saw the deceased alive on April 15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Manuel Levin				23B. DATE SIGNED 4/15/71		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN MD	
23D. ADDRESS 614 Park Heights Ave. Belle Me 21215				23E. FLUNERAL DIRECTOR Frank M. Seely ADDRESS 814 W 36th St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/17/71		24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMT		24D. LOCATION (City, town, or county) (State) PIRESVILLE, BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971				25B. NAME OF REGISTRAR Frank M. Seely			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

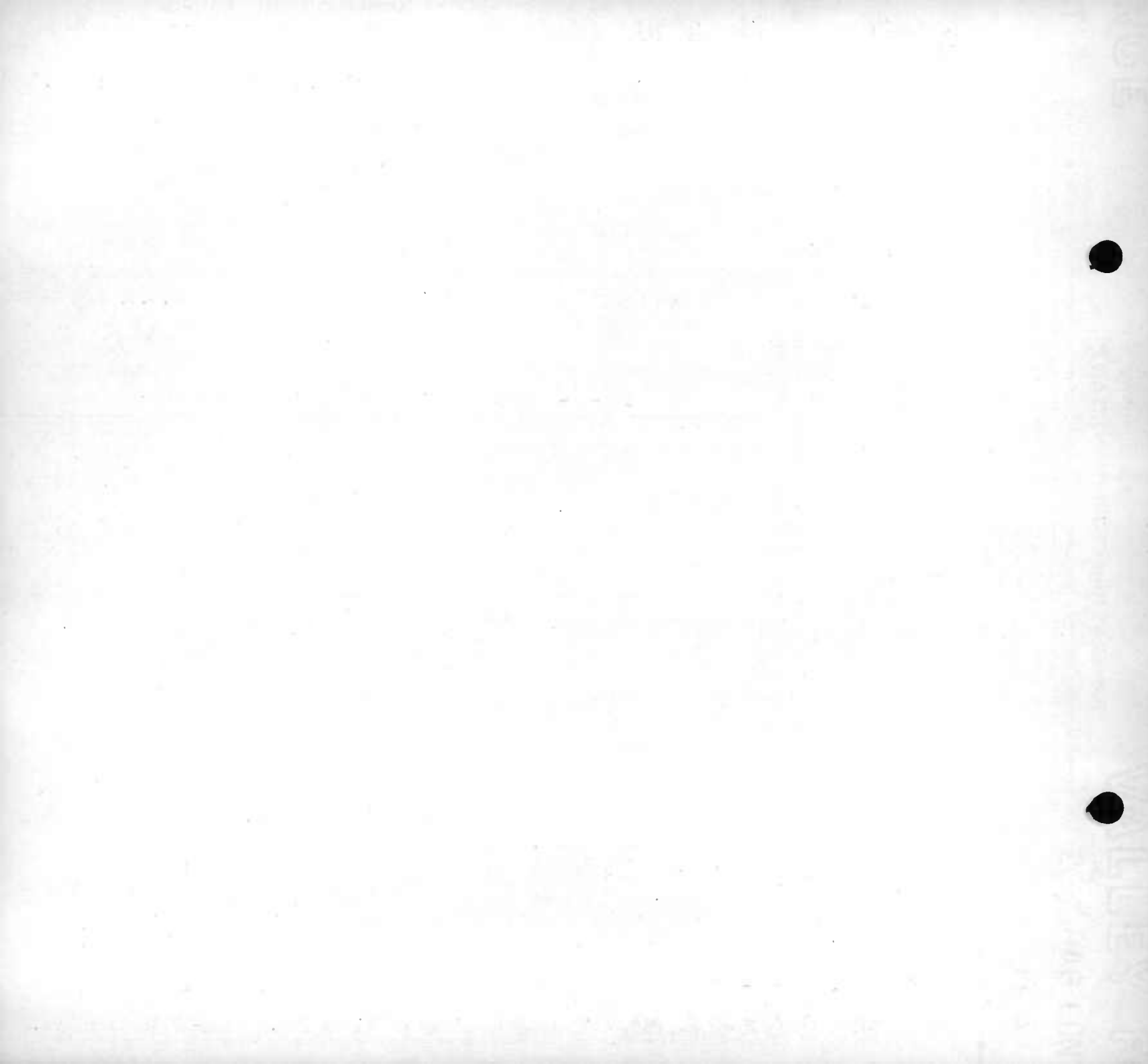
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3749</u>	
W-410		71 3749		CERTIFICATE OF DEATH	
BIRTH NO. <u>W-410</u>		1. NAME OF DECEASED (Type or Print) <u>Anna W. Wolf (Thomson)</u>		2. DATE AND HOUR OF DEATH <u>April 15, 1971</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Wesley Home</u> <u>2211 West Rogers Avenue</u> <u>Baltimore, Maryland 21209</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/7/1891</u>		9. AGE (In years last birthday) <u>80</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>Ebenezer Thomson</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. (Wright)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-52-1195 J1</u>		17. INFORMANT <u>903 Winhall Way 20900</u> <u>Mr. Frank Henry Silver Spring, Md.</u>	
18. <u>41231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral hemorrhage</u> <u>Arteriosclerotic Heart Disease</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9 September</u> 19 <u>68</u> to <u>15 April</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>14 April</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John W. Barnaby M.D.</u>		23B. DATE SIGNED <u>15 Apr 71</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHN W BARNABY</u>	
23D. ADDRESS <u>1652 E. Belvedere Ave</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4/17/1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Stone Chapel Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>John W. Barnaby</u>		25C. FUNERAL DIRECTOR <u>8728 Liberty Road</u> <u>Loring Byers Funeral Directors 21133</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320		71 3750		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3750	
1. NAME OF DECEASED (Type or Print) MARGARET M. GOETZ				2. DATE AND HOUR OF DEATH April 17, 1971 4:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3700 Foster Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2609			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3700 Foster Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1904	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Lang				14. MOTHER'S MAIDEN NAME Anna Fisher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-5108 B		17. INFORMANT ADDRESS Emil Goetz 3700 Foster Avenue			
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ARTERIOSCLEROTIC C.V. DISEASE GENERALIZED ARTERIOSCLEROSIS ARTERIOGLAR NEPHROSCLEROSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YRS 3 YRS 2 YRS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from SEPT. 1 1968 to 4/17 1971 , that (I) was last saw the deceased alive on 4/17 1971 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE Henry J. Houska MD				23B. DATE SIGNED 4/19/71		23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-1971		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robt E. Taylor MD		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>D-552</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3751</u>			
1. NAME OF DECEASED (Type or Print) <u>Downing, George C.</u>				2. DATE AND HOUR OF DEATH <u>April 13, 1971 9:00 P</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3105 Belmont Ave., Balto. Md. 21216											
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-10		9. AGE (in years last birthday) 60		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lou Downing				14. MOTHER'S MAIDEN NAME Maggie Woodridge							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-05-0001		17. INFORMANT BCH Records: Baltimore, Maryland 21224				ADDRESS 4940 Eastern Avenue	
18. <u>157.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) <u>Pancreatic Ca</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from <u>April 8</u> 19 <u>71</u> to <u>April 13</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>April 13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Thomas R. Griggs, MD</u>				23B. DATE SIGNED <u>4/13/71</u>							
23C. PHYSICIAN'S NAME (Type) Thomas R. Griggs, M.D.				23D. ADDRESS Baltimore, City Hospitals 4940 Eastern Ave., Balto. Md. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR Mary-Elizabeth Law		ADDRESS 802 Madison Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3752	
BIRTH NO. S-512 71 3752		CERTIFICATE OF DEATH	
1. NAME OF DECEASED DAISEY (Type or Print) DAISEY-SAMPSON		2. DATE AND HOUR OF DEATH APRIL 16 1971 255 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL 4-22-71		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1803 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1002 HOLLINS ST.	
5. SEX F	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 47
13. FATHER'S NAME Hunter Richby		12. CITIZEN OF WHAT COUNTRY? South Carolina	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Bertha Mack	
16. SOCIAL SECURITY NO. 243-36-1527		17. INFORMANT George W. Sampson, 1002 Hollins St. Balto. Md.	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: KIMMEL STEIL - WILSON DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: YRS	
(C) _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to APRIL 13 1971 , that (I) (we) last saw the deceased alive on APRIL 13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE Meyer R. Heyman M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 4/16/71
23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN M.D.		23D. ADDRESS UNIV. OF MD. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 4/21/71	24C. NAME OF CEMETERY OR CREMATORY Wt Calvary	24D. LOCATION (City, town, or county) (State) Brooklyn Md.
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971	25B. NAME OF REGISTRAR John E. Kelly	25C. FUNERAL DIRECTOR Charles A. Rice	ADDRESS 6614 Bowie

V.S. 153

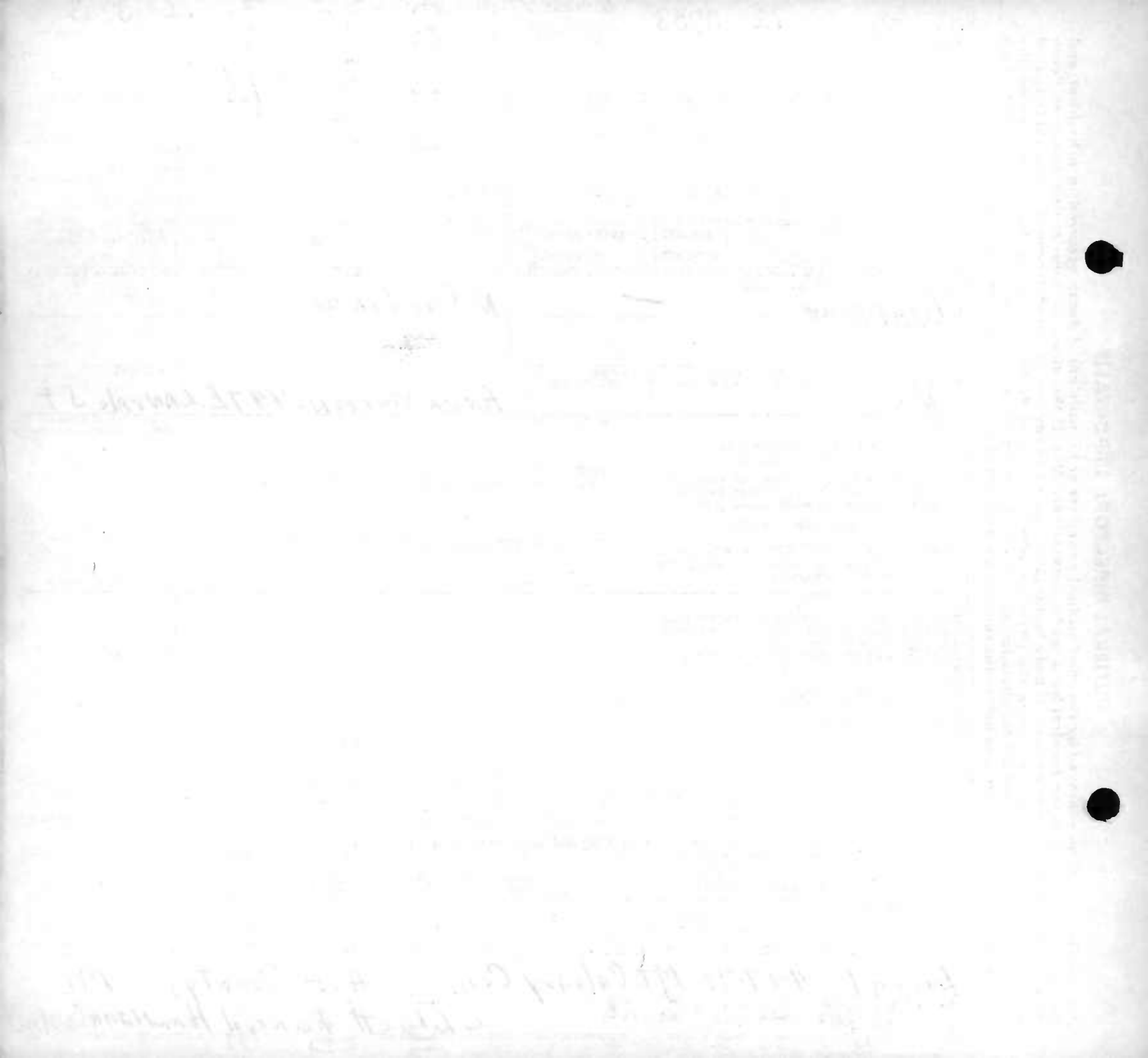
4-22-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) ROOSEVELT WARREN				2. DATE AND HOUR OF DEATH 4-14-71 1:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 806			
5. FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1503 E. LAFAYETTE AVE.			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HENRY ROOSEVELT			14. MOTHER'S MAIDEN NAME Mary Alston				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. (INFORMANT ADDRESS ANNA WARREN - 447 E. LANVALE ST.		
18. 4/10/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: Adult life (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. (INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-8 19 71 to 4-14 19 71 that (I) (we) lost saw the deceased alive on 4-14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce A. Reitz, MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-14-71	
23C. PHYSICIAN'S NAME (Type) BRUCE A. REITZ, M.D.				23D. ADDRESS 601 N. BROADWAY, HOPKINS HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-71		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR John E. ...		25C. FUNERAL DIRECTOR ADDRESS ERLIOTT Funeral Home 129 N. Caroline St.			



This certificate must be approved by the Medical Examiner or Health Officer if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-623		71 3754		BALTIMORE CITY HEALTH DEPARTMENT		71 3754	
1. NAME OF DECEASED (Type or Print) BERTHINA WRIGHT				2. DATE AND HOUR OF DEATH 04-17-71 7:58 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 501 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1208 MC GUBBIN COURT			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-13-05	9. AGE (in years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MITCHELL				14. MOTHER'S MAIDEN NAME ROSIE HARRIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Lillie Mae Spaine 1119 N. Caroline St.			
18. 470.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Possible myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4/17 19 71 to 4/17 19 71 that (1) (we) last saw the deceased alive on 4/17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K. Kramer				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) KARL J. KRAMER	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-21-71		24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Albert J. ...		25C. FUNERAL DIRECTOR Elbert J. H. 1129 N. Caroline St.		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 3755	
BIRTH NO. B-656				71 3755			
1. NAME OF DECEASED (Type or Print) Marie M. Barnheart (Ortloff)				2. DATE AND HOUR OF DEATH April 15, 1971 11:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 9300 Orbitan Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26, 1900	9. AGE (in years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Ruoff				14. MOTHER'S MAIDEN NAME Schorr			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-12-4685		17. INFORMANT ADDRESS 9300 Orbitan Rd. Balto, M William Ortloff Jr.	
18. 481X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Lobar Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Multiple Strokes Multiple Contractures				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/15/71 to 4/16/71 and that (I) (we) last saw the deceased alive on 4/15/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alfred B. Brandy				23B. DATE SIGNED 4/16/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-19-71		Baltimore Cemetery		North Ave Balto Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 19 1971		Robert E. Bailey, Jr.		Frederick Cook		7200 Harford Rd	



1
F 640

BALTIMORE CITY HEALTH DEPARTMENT

71 3756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3756

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)EMC
DUNCAN FAIRLEY2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE PRONOUNCED DEAD Month Day Year Hour
4 10 1971 7:20 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY 1503

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Dec, 19, 1957

10. AGE (In years last birthday)

12

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1708 Warwick Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Daniel Fairley

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chief (Student)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Evelyn Belle Willis

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Daniel Fairley 1740 Warwick Ave.

19. E9229

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
1708 Warwick Ave. 150322D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour)
4-10-71 P m.22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot accidentally by friend.

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/11/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 15, 1971

24C. NAME OF CEMETERY or CREMATORY

Arbuthnot Memorial Park

24D. LOCATION (City, town, or county) (State)

Arbuthnot

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1971

25B. NAME OF REGISTRAR

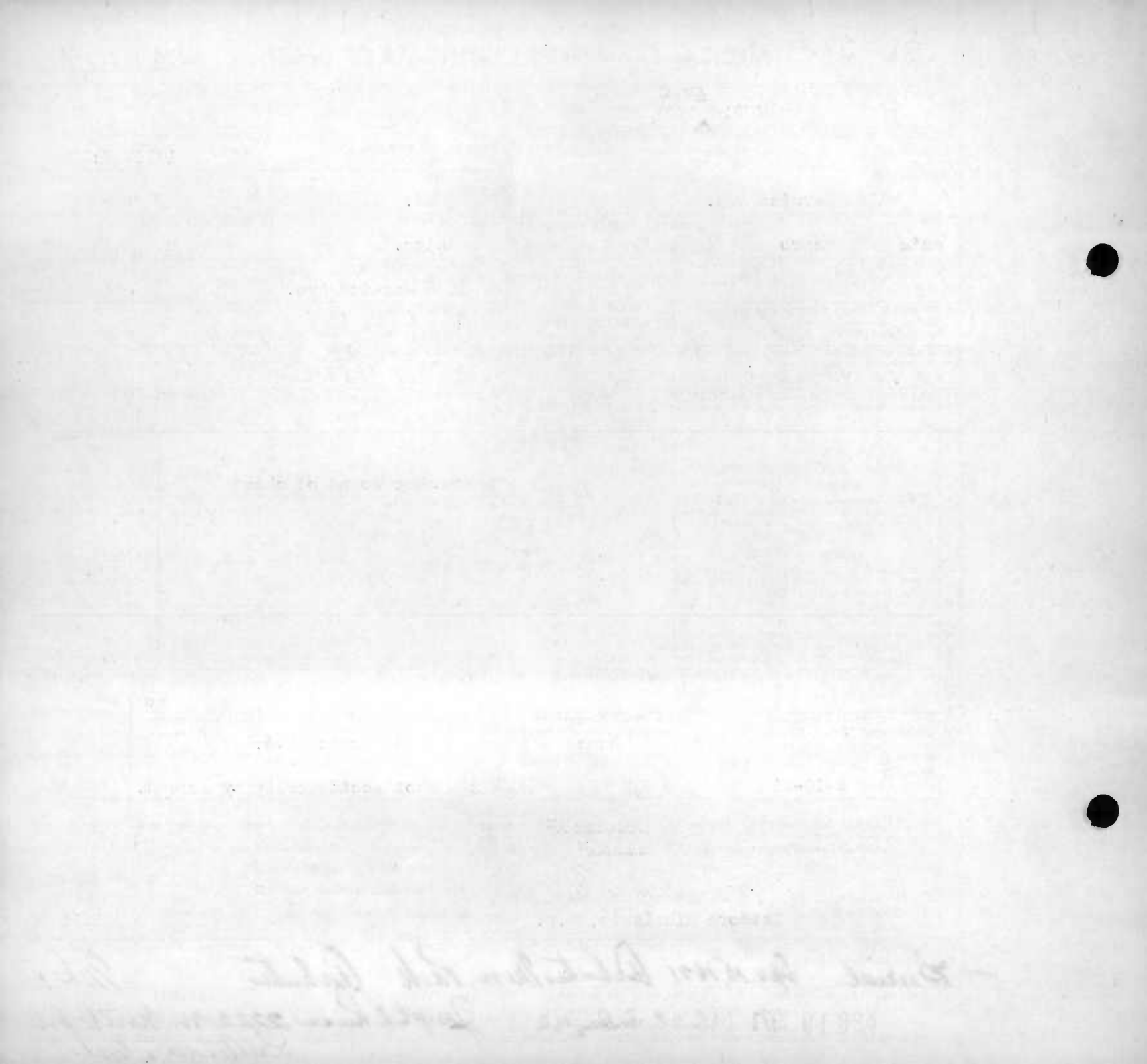
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Joseph H. Hume

ADDRESS

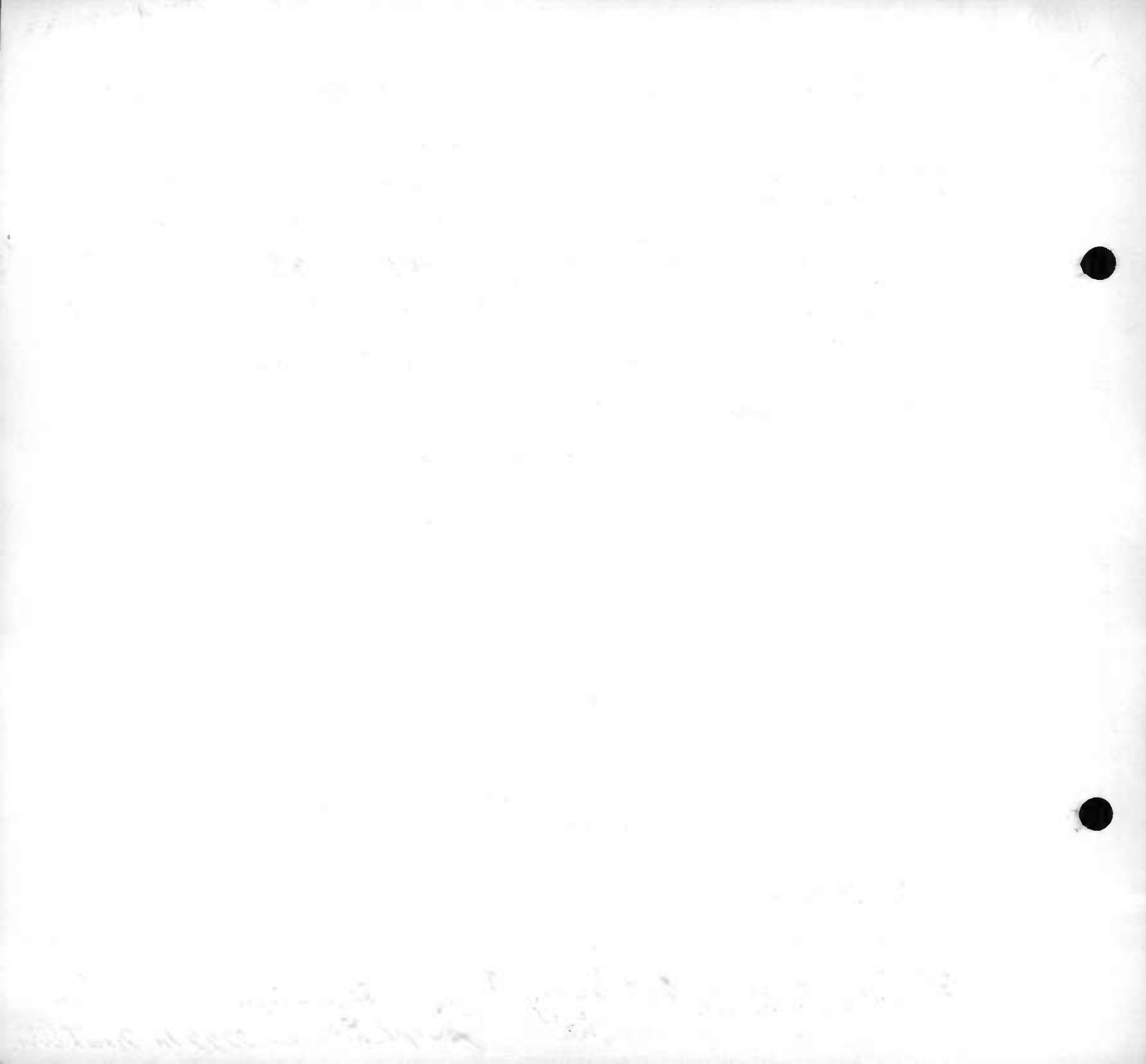
2222 W. North Ave. Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3757</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>71 3757</u>		1. NAME OF DECEASED (Type or Print) <u>Mamie R. Towles</u>		2. DATE AND HOUR OF DEATH <u>4-17-71</u> <u>4:55 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lake Drive Nursing Home</u> <u>2401 Eutaw Place</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1502</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1528 McKean Ave. (21217)</u>		
5. SEX <u>Fe</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>James Henderson</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
14. MOTHER'S MAIDEN NAME <u>Carrie Brown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4-12-71</u> <u>CARDIAC ARREST.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD. + ASCVD.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-19</u> <u>1969</u> to <u>4-16</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>4-14</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>V. Alhman</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. F. McBurnie</u>		23D. ADDRESS <u>7935 Pipers Path Glen Burnie MD 21061</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-21-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph H. Rowe</u> <u>2222 M. North Ave.</u>			



M 324

71 3758

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3758

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM MITCHELL

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

3. DATE

Month

Day

Year

Hour

P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION

33 JOHNS HOPKINS HOSPITAL

6-11-71

April 6, 1971

2:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

833

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Mar. 23, 1913

10. AGE (In years last birthday)

57

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1034 N. Milton Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William H. Mitchell

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Radio Clerk

14B. KIND OF BUSINESS OR INDUSTRY

U.S. P.O.

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

212-613551

18. INFORMANT

ADDRESS

Miss Barbara Mitchell 2512 E. Eager St.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

19. 571.81

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE Fatty metamorphosis of liver

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/7/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-13-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

Brooklyn

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1971

25B. NAME OF REGISTRAR

Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

Joseph H. Hines 2222 W. North Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3759</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>71 3759</u>					
1. NAME OF DECEASED (Type or Print) <u>PAULINE WITKOWSKI</u>		2. DATE AND HOUR OF DEATH <u>4-17-71</u> <u>10 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>607 S. DECKER AVE</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>105</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2104 BANK ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1889</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>WALENTY TRZCINSKI</u>		14. MOTHER'S MAIDEN NAME <u>BYSTRY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 015739</u>		17. INFORMANT <u>WALTER WITKOWSKI 709 S. LAKEWOOD AVE</u>	
18. <u>427.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Acute Pulmonary Embolism</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
19A. DATE OF OPERATION <u>?</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>?</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>?</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> 19 <u>70</u> to <u>4-17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore T. Wizeurik</u>				23B. DATE SIGNED <u>4-19-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Theo. T. WIZEURIK MD</u>				23D. ADDRESS <u>429 S. Chester St 21231</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-21-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY DUNDALK MARYLAND</u>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, RD.</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WEBER & SONS INC 401 S. CHESTER ST</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 3760

BIRTH NO. 71 3760

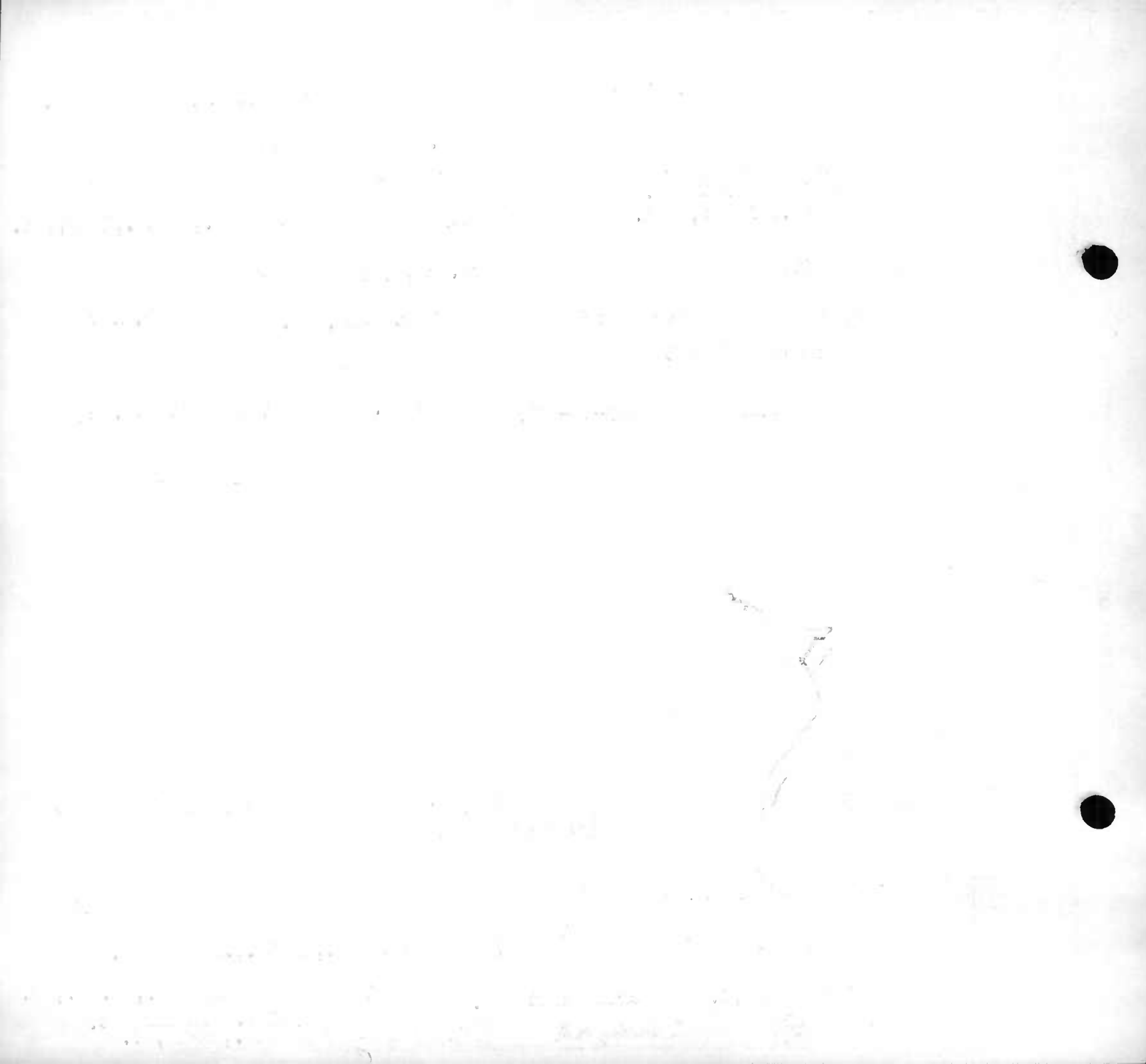
1. NAME OF DECEASED (Type or Print) STEPHEN LEO DUDA		2. DATE AND HOUR OF DEATH 4/15/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3768 RAVENWOOD AVE		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2643 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3768 RAVENWOOD AVE	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/1922
9. AGE (In years last birthday) 48		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER DUDA		14. MOTHER'S MAIDEN NAME AMELIA KORITKOWSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II		16. SOCIAL SECURITY NO. 213 18 7123	
17. INFORMANT LOUISE DUDA		ADDRESS 3768 RAVENWOOD AVE	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage		1 d	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral metastases		2 mos	
(C) Carcinoma of the Hypopharynx		1 y	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/6/67 19 68 to Present 19 71 and that (I) (we) last saw the deceased alive on 4/8 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George J. Richards, Jr. M.D.		23B. DATE SIGNED 4/16/71	
23C. PHYSICIAN'S NAME (Type) George J. Richards, Jr. M.D.		23D. ADDRESS 6701 N. Charles St Balto, Md 21204	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-19-71	
24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM.		24D. LOCATION DUNDALK MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR JOHN M. WIEBER & SONS INC	
25C. FUNERAL DIRECTOR		ADDRESS 4015 CHESTER ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		71 3761	
S16371 3761		BIRTH NO.		1	
1. NAME OF DECEASED (Type or Print) ANNA M. SEIFERT			2. DATE AND HOUR OF DEATH April 17, 1971 5:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Haven Nursing Home 3939 Penhurst Ave. Balto., 21215, Md.			A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Rosedale D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8129 Old Philadelphia Rd., Balto., 21237, Md.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1905	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Anthony Kispert			14. MOTHER'S MAIDEN NAME Mary ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-20-4059		17. INFORMANT ADDRESS Clarence H. Nassner 7406 Falt Ave. #24	
18. CAUSE OF DEATH 7/2/3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 31, 1970 to April 17, 1971 that (I) (we) last saw the deceased alive on April 12, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz			23B. DATE SIGNED April 19, 1971		
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ			23D. ADDRESS 7501 Liberty Rd., Balto., 21207, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-71		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cem.	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR Charles L. Spiller	
				ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3762

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruby Weckesser (Vest)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 19 Year 71 Hour 5:55 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1428 Mill Race Road		3. DATE PRONOUNCED DEAD Month 4 Day 19 Year 71 Hour 5:55 a. M.	
6. SEX female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH May 16, 1910		10. AGE (In years lost birthday) 60	
11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker		14B. KIND OF BUSINESS OR INDUSTRY Hooper Mill	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 226-18-7006	
15. MOTHER'S MAIDEN NAME Weltcher		18. INFORMANT A. L. Pribble, 3214 Nelson St., Lynchburg, Virginia	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Terminal Carcinoma of breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/19/71	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Lynchburg, Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS Donovan Funeral Home, 3818 Roland Avenue	

WALLINGFORD

WALLINGFORD

WALLINGFORD

WALLINGFORD

WALLINGFORD

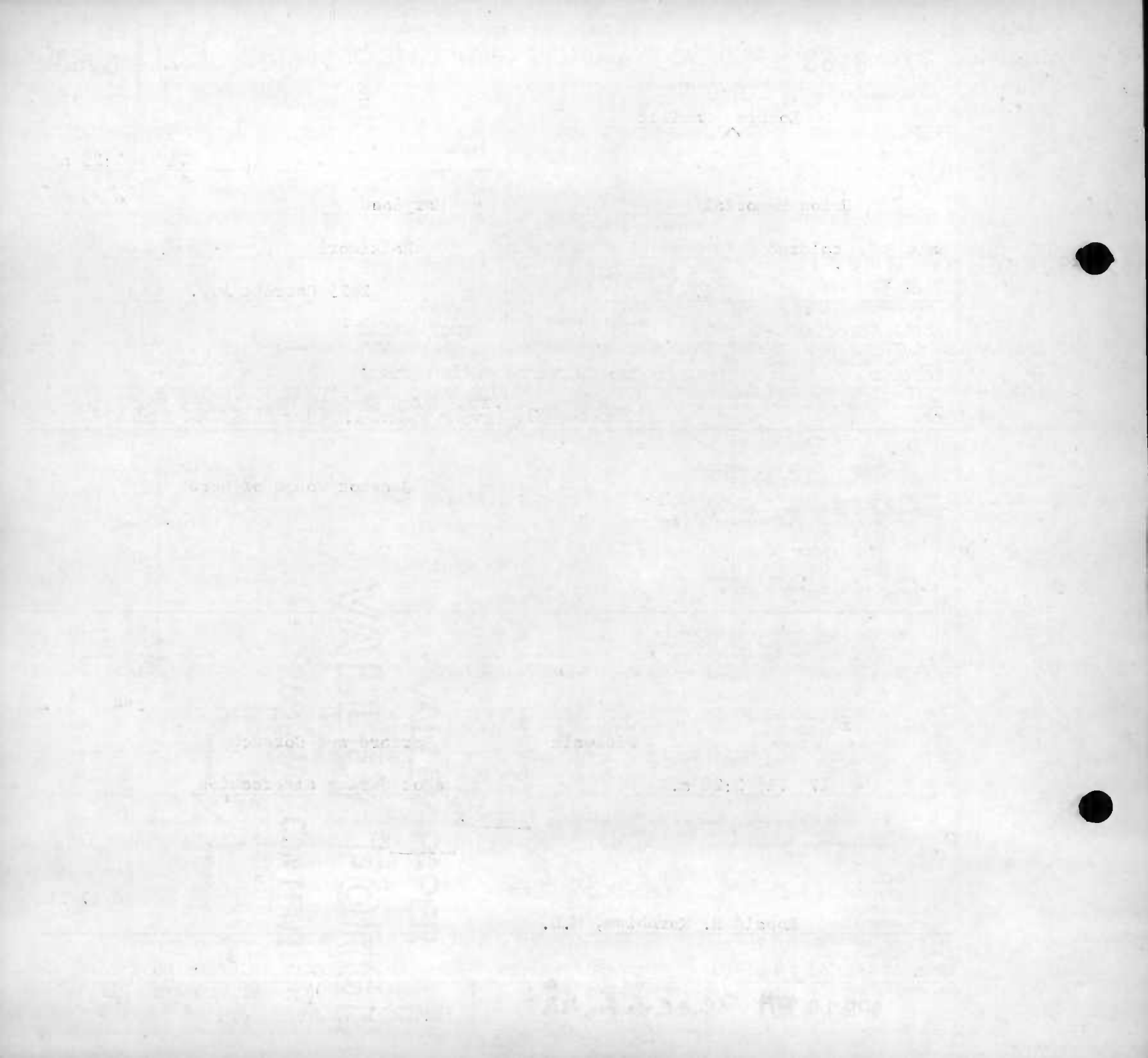
WALLINGFORD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3763

BIRTH NO. 71 3763

1. NAME OF DECEASED (Type or Print) Paul Lonnie Hamlett		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 71 2:25 a.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 907	
9. DATE OF BIRTH 7-22-54		10. AGE (In years lost birthday) 17	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Percy Hamlett		14. MOTHER'S MAIDEN NAME Helen Wilson	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		16. KIND OF BUSINESS OR INDUSTRY Pa. Produce Terminal	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. 246-84-3819	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk	
25. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 17 71 2:20 a.m.		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Harford and Gorsuch 907		28. HOW DID INJURY OCCUR? shot during altercation	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
31. ACTUAL SIGNATURE (Type) Ronald N. Kornblum, M.D.		32. DATE SIGNED 4/17/71	
33. DATE REC'D BY HEALTH DEPT. APR 19 1971		34. NAME OF REGISTRAR R. E. Taylor, M.D.	
35. DATE OF BURIAL CREMATION, REMOVAL (Specify) transit-burial 4-22-71		36. NAME OF CEMETERY or CREMATORY Semora Cemetery	
37. LOCATION (City, town, or county) (State) Semora, N. Carolina		38. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3784	
BIRTH NO. 71 3784		2. DATE AND HOUR OF DEATH 5/16/71 3:15 PM	
1. NAME OF DECEASED (Type or Print) TONYA WALKER		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE PENN. B. COUNTY V-35	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN York D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 680 N. BEAVER STREET	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		9. AGE (In years last birthday) 8 YRS	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NELSON JOHNSON		14. MOTHER'S MAIDEN NAME DEBRA WALKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. n/a	17. INFORMANT Debra Walker, 680 N. Beaver St., York, Pa.
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) NEUROBLASTOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 YEARS	
19A. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) No	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/14 1971 to 4/16 1971 that (I) (we) last saw the deceased alive on 4/16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Winifred B. Parker MD		23B. DATE SIGNED 4/16/71	
23C. PHYSICIAN'S NAME (Type) WINIFRED B. PARKER		23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/71	
24C. NAME OF CEMETERY OR CREMATORY Greenmont Cemetery		24D. LOCATION (City, town, or county) (State) York City, York, Pa.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOMES, INC.		25D. ADDRESS 1701-31 Laurens Street, Balto., Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3765</u>	
BIRTH NO. <u>71 3765</u>		1. NAME OF DECEASED (Type or Print) <u>Smith Ida J.</u>		2. DATE AND HOUR OF DEATH <u>4-15-71</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1606</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital Baltimore, Md #6</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-14-12</u>		9. AGE (In years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia, Prince George's Co.</u>	
13. FATHER'S NAME <u>William Allen</u>		14. MOTHER'S MAIDEN NAME <u>Hester Allen</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hester Lewis</u>	
18. <u>450X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pulm. Embolism & pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-17-71</u> <u>~ 4/15/71</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-17-71</u> to <u>4-15-71</u> that (I) (we) lost saw the deceased alive on <u>4-15-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>O. J. Kim M.D.</u>				23B. DATE SIGNED <u>4-15-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>OK JA Kim O. Kim</u>		23D. ADDRESS <u>730 Ashburton St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-19-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Prince George's VA</u>	
24D. LOCATION (City, town, or county) (State) <u>Prince George's VA</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Marjorie D. Pett F.H. 1201-1201</u>			

2814 W. Lanvale

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>B 620 71 3766</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3766</u>	
1. NAME OF DECEASED (Type or Print) <u>BROOKS, BERNICE</u>				2. DATE AND HOUR OF DEATH <u>4/14/71 12¹⁰ PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>2600 Liberty Heights Avenue</u> <u>Baltimore, Maryland 21215</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2802</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4502 Springdale Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-26</u>		9. AGE (In years last birthday) <u>44</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Abner Christian</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Pankey</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-20-1078</u>		17. INFORMANT <u>Mr. Merrick L. Brooks- Husband</u>		ADDRESS <u>SAME</u>	
18. <u>162.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>ANOXIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bilateral pleural effusion</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Carcinoma RIGHT LUNG</u> <u>WITH METASTASES</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-6 hours</u> <u>1-2 months</u> <u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1970</u> to <u>APRIL 1971</u> that (I) (we) last saw the deceased alive on <u>14 APRIL 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ferdinand Leacock</u>				23B. DATE SIGNED <u>4/14/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Ferdinand Leacock, M.D.</u>	
23D. ADDRESS <u>2600 Liberty Heights Avenue</u>				23E. CITY OR TOWN <u>Balto., Md. 21215</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-19-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor, M.D.</u>		ADDRESS <u>4400 N. MORTIMER ST. A. DOWNEY</u>	

1000 Liberty Bell Association
Baltimore, Maryland 21213

4532 Springdale Avenue

2-14-77

X

negro

female

Registered Nurse

Abner Christian

270-20-1078 Mr. Herbert L. Brooks - Baltimore

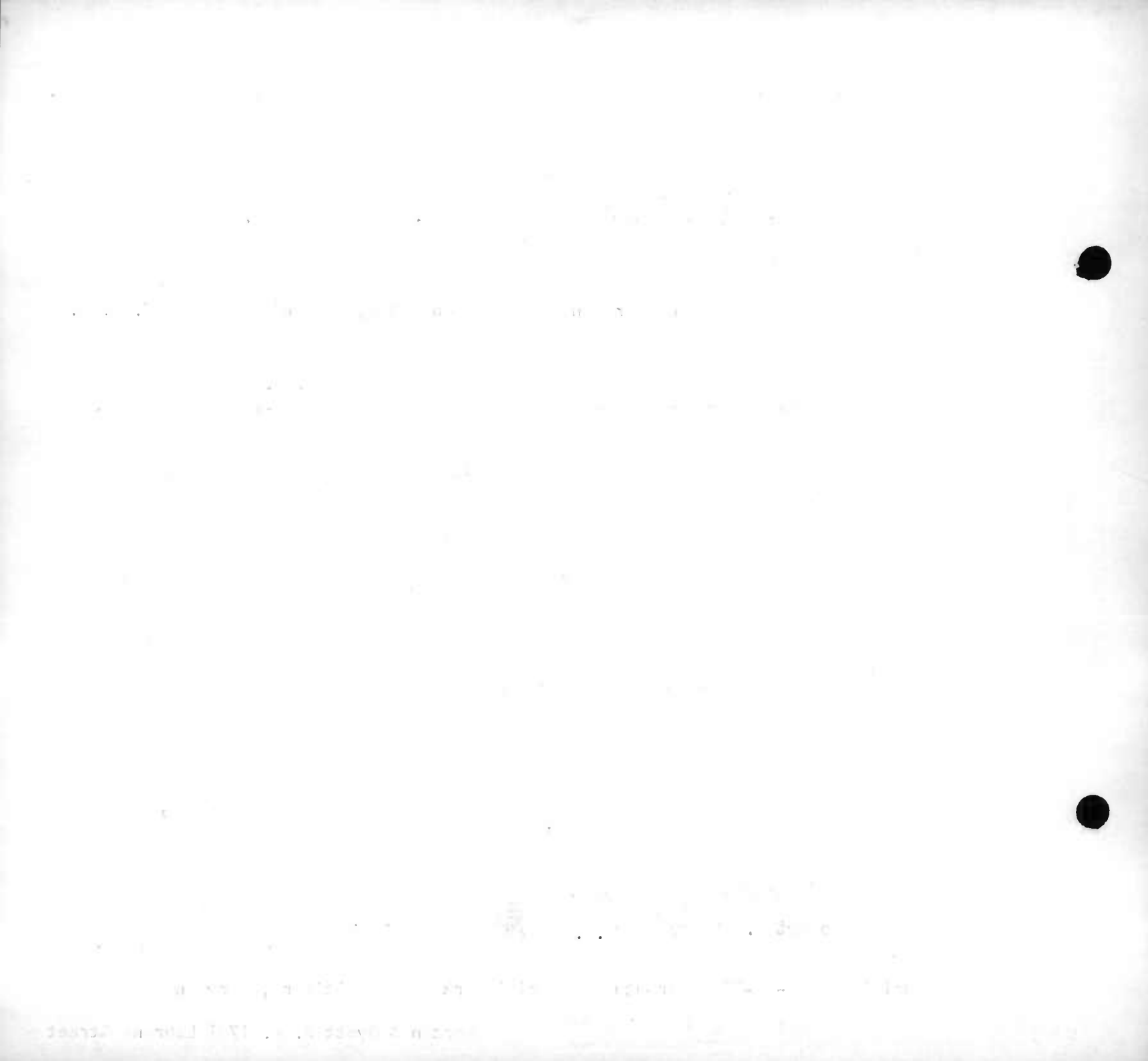
NO

Ferdinand Leach, M.D.

1500 Liberty Bell Association

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3767</u>	
BIRTH NO. <u>71 3767</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>EDMONDS, BENNIE (NMI)</u>			2. DATE AND HOUR OF DEATH <u>April 13, 1971</u> <u>6:55 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1601</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>930 N. Carrollton Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-93</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Longshoreman</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster, Virginia</u>	
13. FATHER'S NAME <u>Esau Edmonds</u>			14. MOTHER'S MAIDEN NAME <u>Ida Wilson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>4-27-18 to 4-12-19</u>		16. SOCIAL SECURITY NO. <u>217-09-2511</u>		17. INFORMANT <u>Records V. A. Hospital</u> ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Md.</u>	
18. <u>444-71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Massive pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Venous thrombosis, lower extremities</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Arterial thrombosis, Right leg</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>24 hours</u> <u>4 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Clostridial septicemia</u>		<u>24 hours</u>
19A. DATE OF OPERATION <u>4/13/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Amputation, Right leg</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>March 31</u> 19 <u>71</u> to <u>April 13</u> , 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>April 13</u> , 19 <u>71</u> and that (3) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Darryl Fisher MD</u>				23B. DATE SIGNED <u>April 14, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert D. Fisher</u> M.D.				23D. ADDRESS <u>V. A. Hospital</u> <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-16-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F. H.</u> ADDRESS <u>1701 Laurens Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3768	
C-2710 3768		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DORETHA COSBY		4-17-71 5:25 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 2600 Liberty Heights Ave, Baltimore, Maryland 21215			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3621 Rosedale Road		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-11-34	9. AGE (In years last birthday) 36
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank Blackwell, Sr.		14. MOTHER'S MAIDEN NAME Lucinda Blackwell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-30-9596		17. INFORMANT Mr. Ronald Cosby- Husband	
				ADDRESS SAME	
18. 446.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Collagen Vascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks
			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Failure and Pericarditis		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1, 71 to April 17, 71 that (I) (we) last saw the deceased alive on April 17, 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders M.D.				23B. DATE SIGNED 4-17-71	
23C. PHYSICIAN'S NAME (Type) Elijah Saunders M.D.				23D. ADDRESS 2600 Liberty Heights Ave. Balto., Md. 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens St. 21217	

... ..
... ..
... ..

... ..
... ..
... ..

... ..

... ..
... ..
... ..

April 14, 1941

April 14, 1941

April 14, 1941

April 14, 1941

April 14, 1941

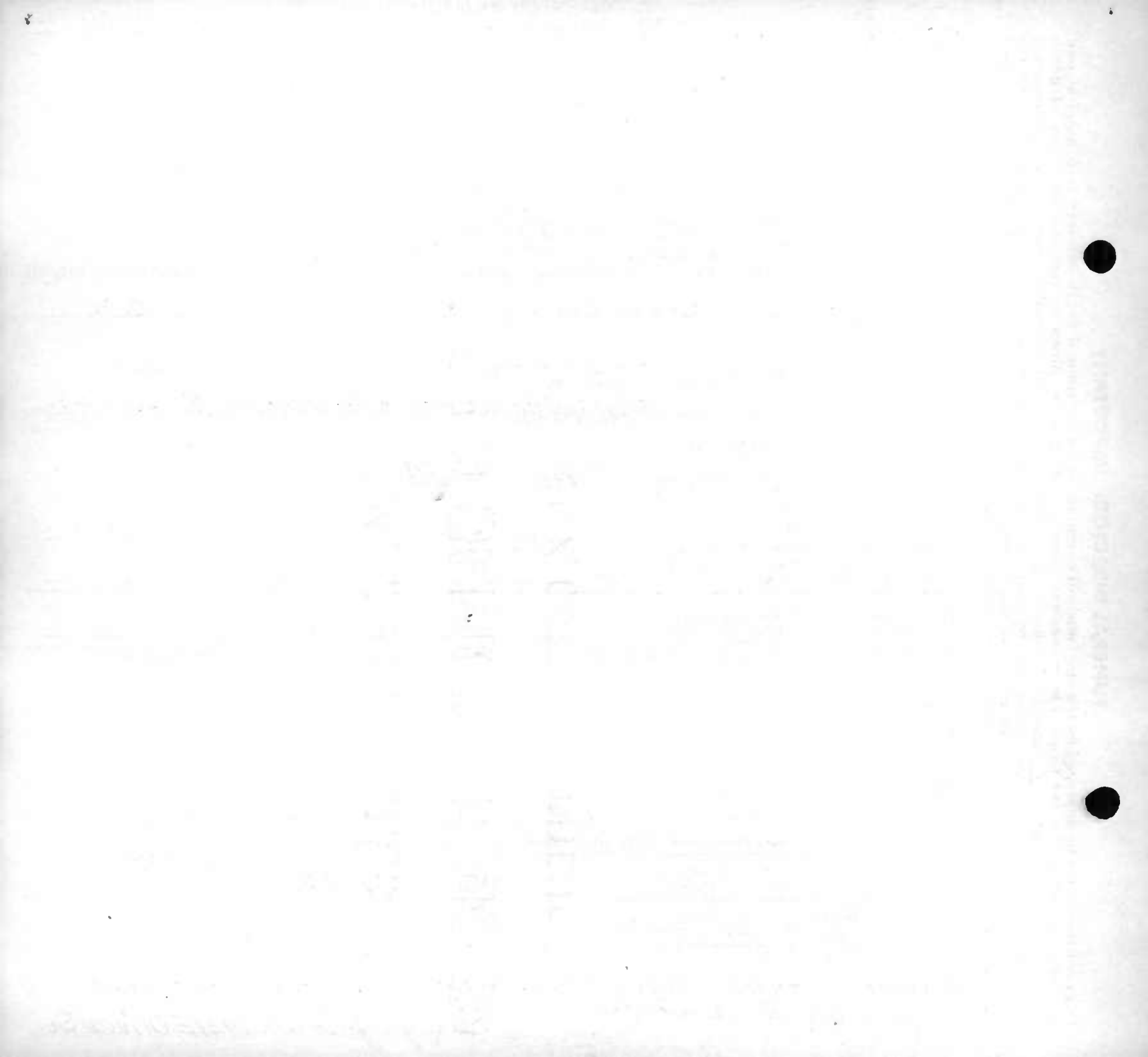
April 14, 1941

April 14, 1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>F-622 71 3769 CERTIFICATE OF DEATH</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 71 3769</p>	
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">FERGEST, Andrew</p>		<p>2. DATE AND HOUR OF DEATH 4-15-71 6:00 A M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>33 The Johns Hopkins Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland 909</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p>		<p>C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
		<p>E. STREET AND NUMBER 1605 Harford Avenue</p>	
<p>5. SEX Male</p>	<p>6. RACE Negro</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 6/14/16 14</p>
		<p>9. AGE (In years last birthday) 54</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer</p>
		<p>11. BIRTHPLACE (State or foreign country) Virginia</p>	<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>
<p>13. FATHER'S NAME James Fergest</p>		<p>14. MOTHER'S MAIDEN NAME Bessie Jones</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 217-18-2925</p>	
		<p>17. INFORMANT ADDRESS Mrs. Mollie Fergest, 1605 Harford Ave</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE Uremia DUE TO, OR AS A CONSEQUENCE OF:</p>	
		<p>(B) Hypernephroma DUE TO, OR AS A CONSEQUENCE OF:</p>	
		<p>(C)</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 4/15/71</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 4/7 19 71 to 4/15 19 71 that (I) (we) last saw the deceased alive on 4/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>John M. Amatruda</i></p>		<p>23B. DATE SIGNED 4/15/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) John M. Amatruda</p>		<p>23D. ADDRESS 601 W. Broadway</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 4-19-71</p>	
<p>24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park</p>		<p>24D. LOCATION (City, town, or county) (State) Arbutus, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 19 1971</p>		<p>25B. NAME OF REGISTRAR Charles E. ...</p>	
<p>25C. FUNERAL DIRECTOR Randolph J. Collick</p>		<p>ADDRESS 2431 E. Oliver St.</p>	



FUNERAL DIRECTOR: IMPORTANT

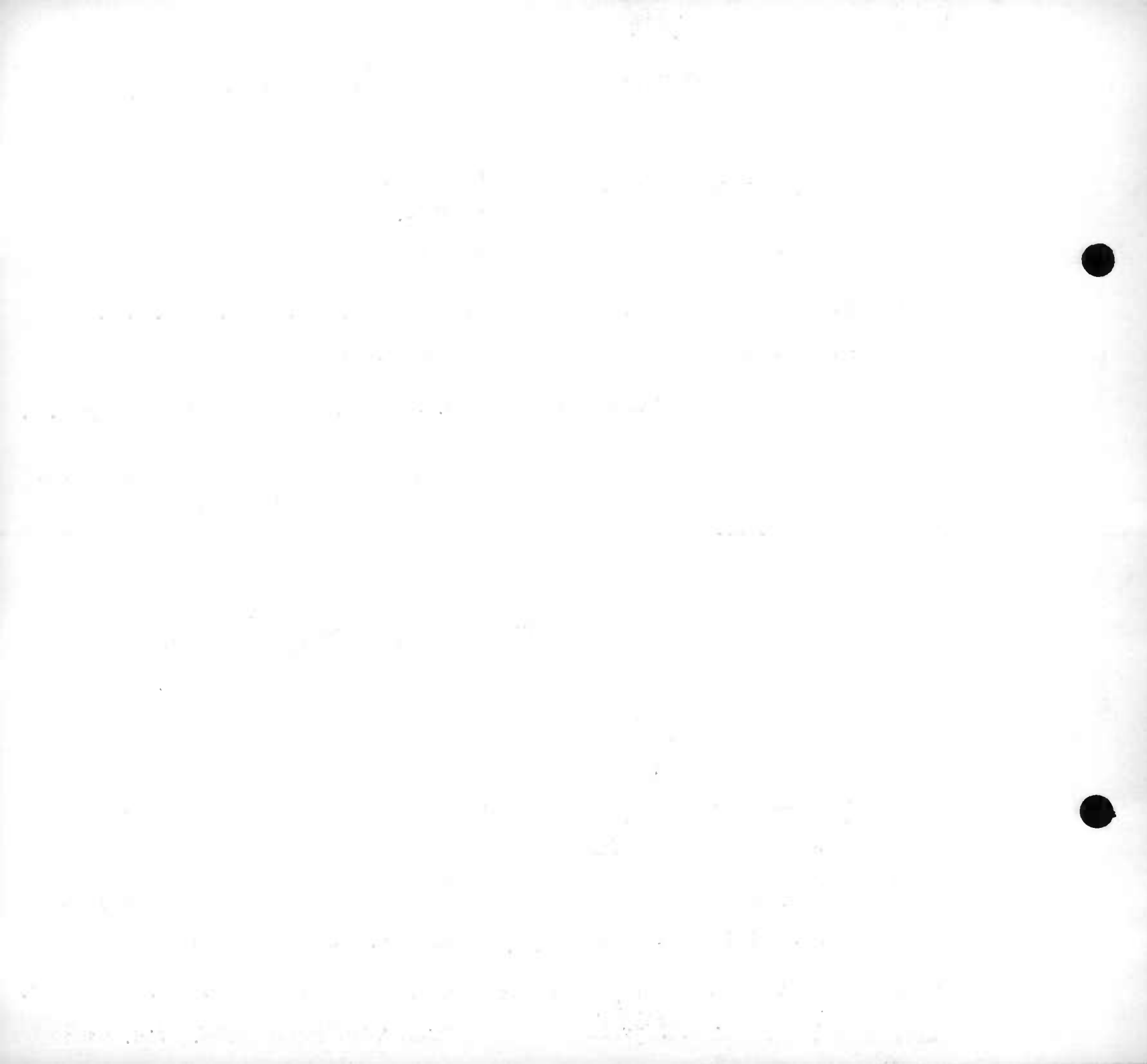
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3770</u>	
BIRTH NO. <u>4-656</u>		71 3770			
1. NAME OF DECEASED (Type or Print) <u>HORNER MARY O.</u>			2. DATE AND HOUR OF DEATH <u>4-16-1971 2:20 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>903</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>806 E. 35th St</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09-06-92</u>	9. AGE (In years last birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Debrick</u>		14. MOTHER'S MAIDEN NAME <u>W. Blanche Holmes</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-36-9502</u>		17. INFORMANT <u>Mrs Fred Steimel Towson, Md.</u>	
18. <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca of Esophagus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>27</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD - HBP - Septic shock</u>					
19A. DATE OF OPERATION <u>3-25-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca Esophagus</u>		20A. AUTOPSY (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-17-1971</u> to <u>4-16-1971</u> that (I) (we) last saw the deceased alive on <u>4-15-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gustavo Hinojosa</u>				23B. DATE SIGNED <u>4-16-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>GUSTAVO HINOJOSA MD</u>				23D. ADDRESS <u>MD General Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-19-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>John E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co., Balto., Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3771	
1-630 71 3771		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary Lillie Foard		April 14, 1971 3:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3700 N. Charles Street			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-1890	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hyes Balto. Co., Md.	
13. FATHER'S NAME Leonard Foard		14. MOTHER'S MAIDEN NAME Mary Lillie Preece			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-46-0727		17. INFORMANT Mr. John D. Harnden Schenectady, N.Y.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma Cecum with Metastases</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 mos</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>15301</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical) examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 70</i> to <i>April 14 71</i> that (I) (we) last saw the deceased alive on <i>April 9 71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>my</i>					
23A. SIGNATURE <i>W.P. Benson, Jr.</i>		23B. DATE SIGNED <i>April 16, 1971</i>		23C. PHYSICIAN'S NAME (Type) Dr. William P. Benson, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-1971		24C. NAME OF CEMETERY OR CREMATORY Fork Methodist Church	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 19 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Faby, M.D.</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
				ADDRESS 4905 York Road Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

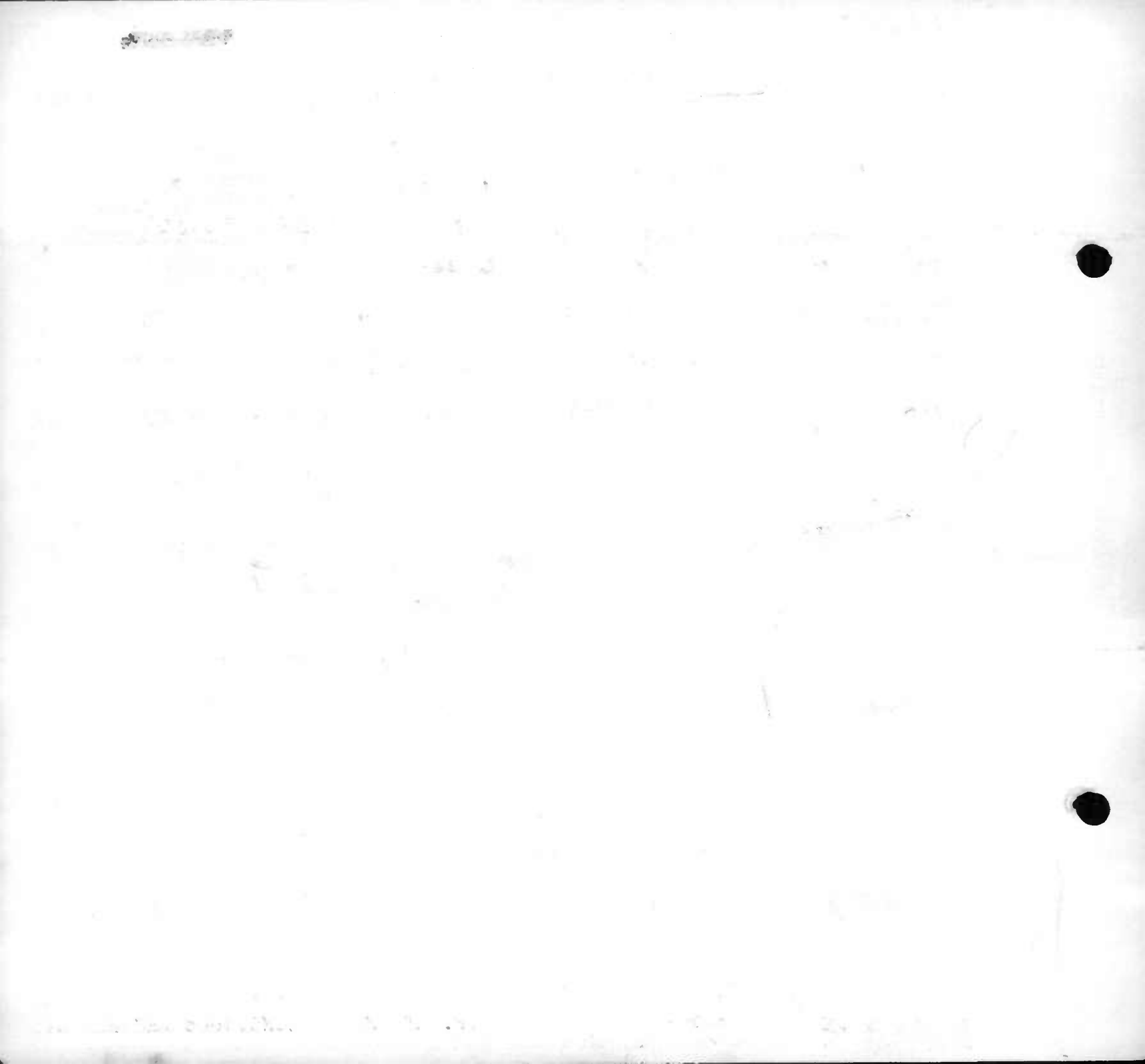
BIRTH NO. <u>H-553</u>				BALTIMORE CITY HEALTH DEPARTMENT				71 3772				CERTIFICATE OF DEATH				REG. NO. <u>71 3772</u>			
1. NAME OF DECEASED (Type or Print) <u>MINNIE B. HAMMOND</u>								2. DATE AND HOUR OF DEATH <u>APRIL 16, 1971</u> <u>8:25 A.</u> M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>-</u>											
FULL NAME OF HOSPITAL OR INSTITUTION <u>4400 N. MARYLAND HOSP.</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>								8. DATE OF BIRTH <u>9-17-87</u>				9. AGE (In years last birthday) <u>83</u>							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JASPER BERRY</u>								14. MOTHER'S MAIDEN NAME <u>MINNIE MAGAUDER</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Miss Jean Hammond</u> <u>MEDICAL RECORD</u>				ADDRESS <u>Same</u>							
18. <u>410,914-2509</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u>								CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>7 days</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>								(B) <u>ACUTE PLEURITIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>7 days</u>				(C) <u>POST MYOCARDIAL INFARCT + P. ARTERIOSCLEROSIS</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>POST MYOCARDIAL INFARCT + P. ARTERIOSCLEROSIS</u>																			
19A. DATE OF OPERATION <u>None</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>				20A. AUTOPSY? (Yes or No) <u>- NO</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>-</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>-</u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>											
21D. TIME OF INJURY (APPROX.) <u>-</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u>-</u>											
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4-8</u> 19 <u>71</u> to <u>4-16</u> 19 <u>71</u> that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>4-16</u> 19 <u>71</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.																			
23A. SIGNATURE <u>Lester A. Reid M.D.</u>								23B. DATE SIGNED <u>4/16/71</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>							
23C. PHYSICIAN'S NAME (Type) <u>LESTER A. REID, M.D.</u>								23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-19-71</u>				24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co. Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Jones, Jr.</u>				25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u>				ADDRESS <u>4905 York Rd. Baltimore, Maryland 21212</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-425 71 3773				Baltimore City Health Department		REG. NO. 71 3773	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Welzant, Mr. Peter</u>				2. DATE AND HOUR OF DEATH <u>4-15-71</u> <u>8:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>103</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2717 Eastern Avenue</u>				F. CITY OR TOWN <u>Baltimore</u>			
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-26-00</u>	
9. AGE (In years last birthday) <u>70 yrs.</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Shipbuilding</u>			
13. FATHER'S NAME <u>George W. Welzant</u>				14. MOTHER'S MAIDEN NAME <u>Jadwiga Lisiecka</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-107-4708A</u>		17. INFORMANT <u>Gerold Welzant</u>	
18. I <u>710-9</u> I <u>1</u> CAUSE OF DEATH				ADDRESS <u>2717 Eastern Avenue, Baltimore, Md.</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute antero-septal infarction of left ventricle</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Occlusion of left anterior descending branch of left coronary artery</u>				DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIO-SCLEROTIC HEART DISEASE</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>4-11</u> 19 <u>71</u> to <u>4-15</u> 19 <u>71</u> that (H) (we) last saw the deceased alive on <u>4-15</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>L. de Borja M.D.</u>				23B. DATE SIGNED <u>4-15-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Lilia L. de Borja M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/19/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>			
25B. NAME OF REGISTRAR <u>W. F. Sadowski</u>				25C. FUNERAL DIRECTOR <u>M. F. SADOWSKI & SONS, 1808 EASTERN AVE</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-620 71 3774 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 71 3774 </div>			
1. NAME OF DECEASED (Type or Print) Myers, HERMAN E.		2. DATE AND HOUR OF DEATH 4-14-71	
3. PLACE IN SALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Y2SINAI Hospital of Balto.		A. STATE Md B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN OWINGS Mills D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER Rosewood State Hospital	
5. SEX M	6. RACE CNU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Licence PRAC. NURSE		10B. KIND OF BUSINESS OR INDUSTRY State Hosp	9. AGE (In years last birthday) 67
13. FATHER'S NAME Heinrich Myers		11. BIRTHPLACE (State or foreign country) GERMANY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 214-30-6068		14. MOTHER'S MAIDEN NAME Jeanne ?	
17. INFORMANT Norma Jean Myers		ADDRESS Rosewood State Hospital Owings Mills, Md.	
18. 4-10-71 CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Acute Myocardial Inf.	
DUE TO, OR AS A CONSEQUENCE OF:		2-3 days	
ANTECEDENT CAUSES		(B) ASCVD	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 4-10-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-14-71 to 4-14-71 that (I) (we) last saw the deceased alive on 4-14-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leonardo E. Vinueza		23B. DATE SIGNED 4/14/71	
23C. PHYSICIAN'S NAME (Type) Leonardo E. Vinueza		23D. ADDRESS SINAI Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/17/71	
24C. NAME OF CEMETERY OR CREMATORY Good Shephard Cem.		24D. LOCATION (City, town, or county) (State) Ellicott City, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.	
25C. FUNERAL DIRECTOR H. J. Schmitt		ADDRESS Owings	

11 2 11

State Hosp

Heinrich Meyer

Texas

12

out-let from township

Revised State Highway
Group with 100

Group 1111 Good Shipping Gen Elliott Group

H. J. Elliott Group

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-260 71 3775		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3775	
1. NAME OF DECEASED (Type or Print) NEUHAUSER MRS. MARY W		2. DATE AND HOUR OF DEATH APRIL 15 1971 13:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY Police		8. DATE OF BIRTH 05 20 21	
11. BIRTHPLACE (State or foreign country) CANADA		9. AGE (In years last birthday) 49		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS A WILLETT		14. MOTHER'S MAIDEN NAME VIOLA GILKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-3479		17. INFORMANT Harrison W Neuhauser	
18. I I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) EXTENSIVE METASTASIS BONE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE YEAR 4 MONTHS		ADDRESS Timber Grove Rd Owings Mills, Md	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ONE YEAR		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA LUNG		(B) DUE TO, OR AS A CONSEQUENCE OF: ONE YEAR	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Approx.) —		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (H) (this hospital) attended the deceased from 4/12/71 19 71 to 4/15/71 19 71 that (H) (we) last saw the deceased alive on 4/15/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A Mehta		23B. DATE SIGNED 4/15/71		23C. PHYSICIAN'S NAME (Type) Dr A MEHTA - MD	
24A. BURIAL CREMATION, REMOVAL (Specify) cremation		24B. DATE 4/16/71		24C. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
24D. LOCATION (City, town, or county) (State) Washington 18, D.C.		25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR J. E. Schmitt	
25C. FUNERAL DIRECTOR A. J. Schmitt		ADDRESS Owings Mills Ind.			

170

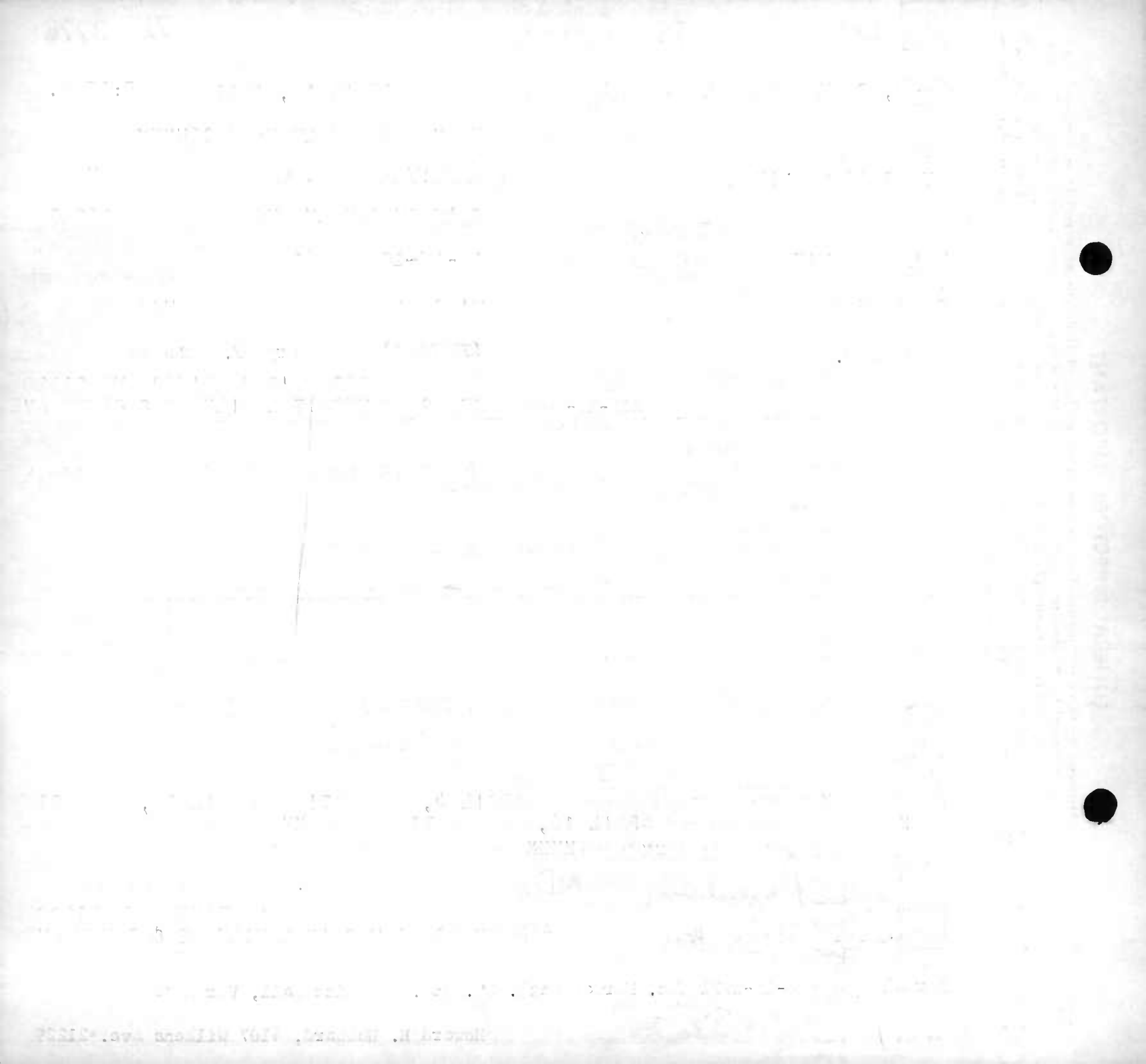
Harvard University

Cambridge, Mass.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3776</u>
BIRTH NO. <u>W-300</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) XXXXXX <u>GROVER CLEVELAND WOOD</u>		2. DATE AND HOUR OF DEATH <u>APRIL 16, 1971</u> <u>5:15 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> <u>40</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE COUNTY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>5945 SUNSET AVENUE</u> <u>21207</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1889</u>	9. AGE (In years last birthday) <u>81</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James F. Wood</u>		14. MOTHER'S MAIDEN NAME XXXXXX <u>Mary F. Thomas</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-18-8940</u>		
17. INFORMANT <u>RECORD'S BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS & CATON AVE</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MIOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>8 days</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <u>4-10-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <u>MIOCARDIAL INFARCTION</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from <u>APRIL 4, 1971</u> to <u>APRIL 16, 1971</u> that (X) (we) last saw the deceased alive on <u>APRIL 16, 1971</u> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE <u>Carlos Rozenblum</u>		23B. DATE SIGNED <u>4.16.71</u>		
23C. PHYSICIAN'S NAME (Type) <u>CARLOS ROZENBLUM</u>		23D. ADDRESS <u>BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS & CATON AVE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-19-1971</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Meth. Ch. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>White Hall, Virginia</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		
25C. FUNERAL DIRECTOR <u>4107 Wilkens Ave. 21229</u>		25D. ADDRESS		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

July 1914



100

100

100

100

100

100

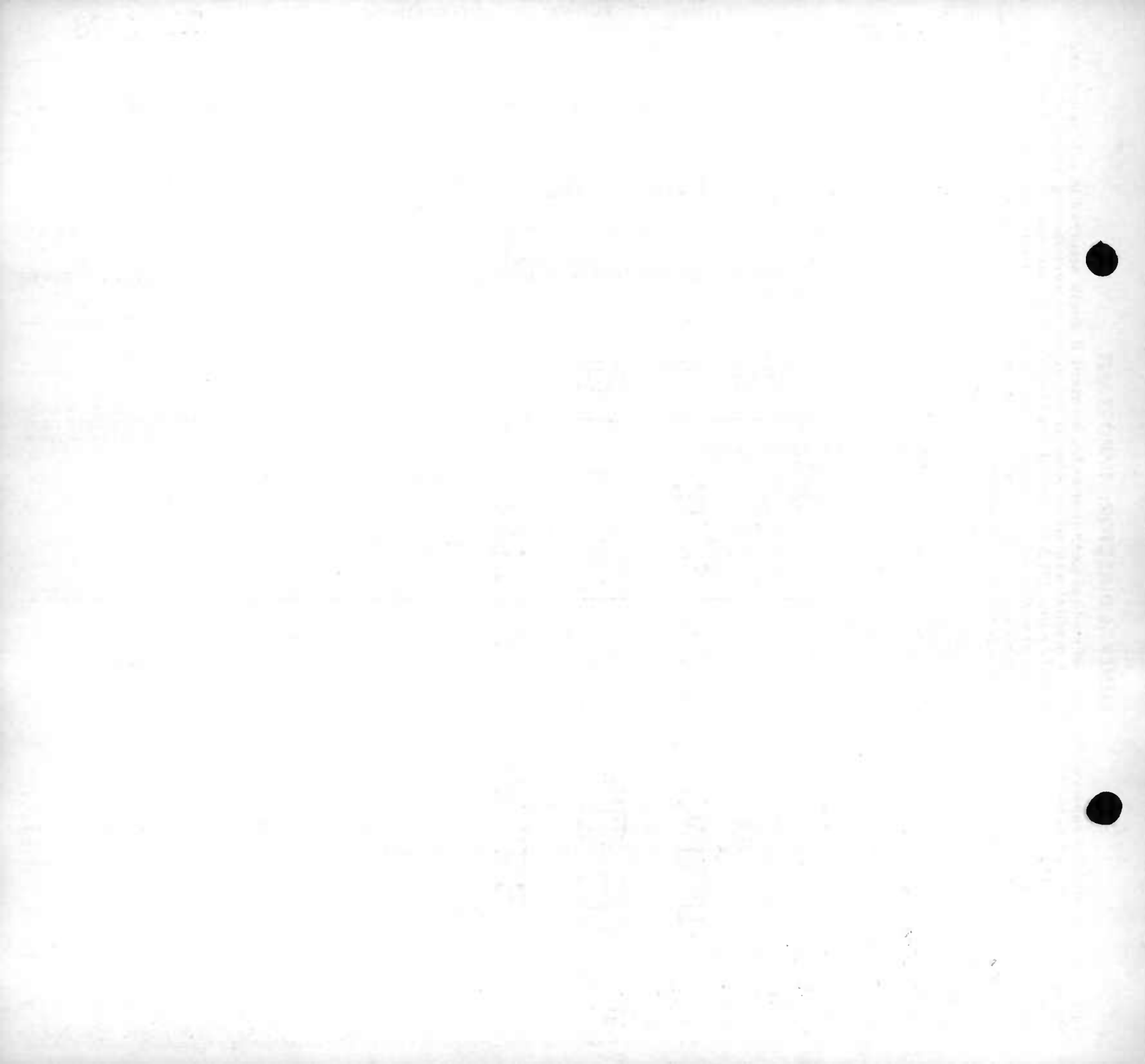
100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

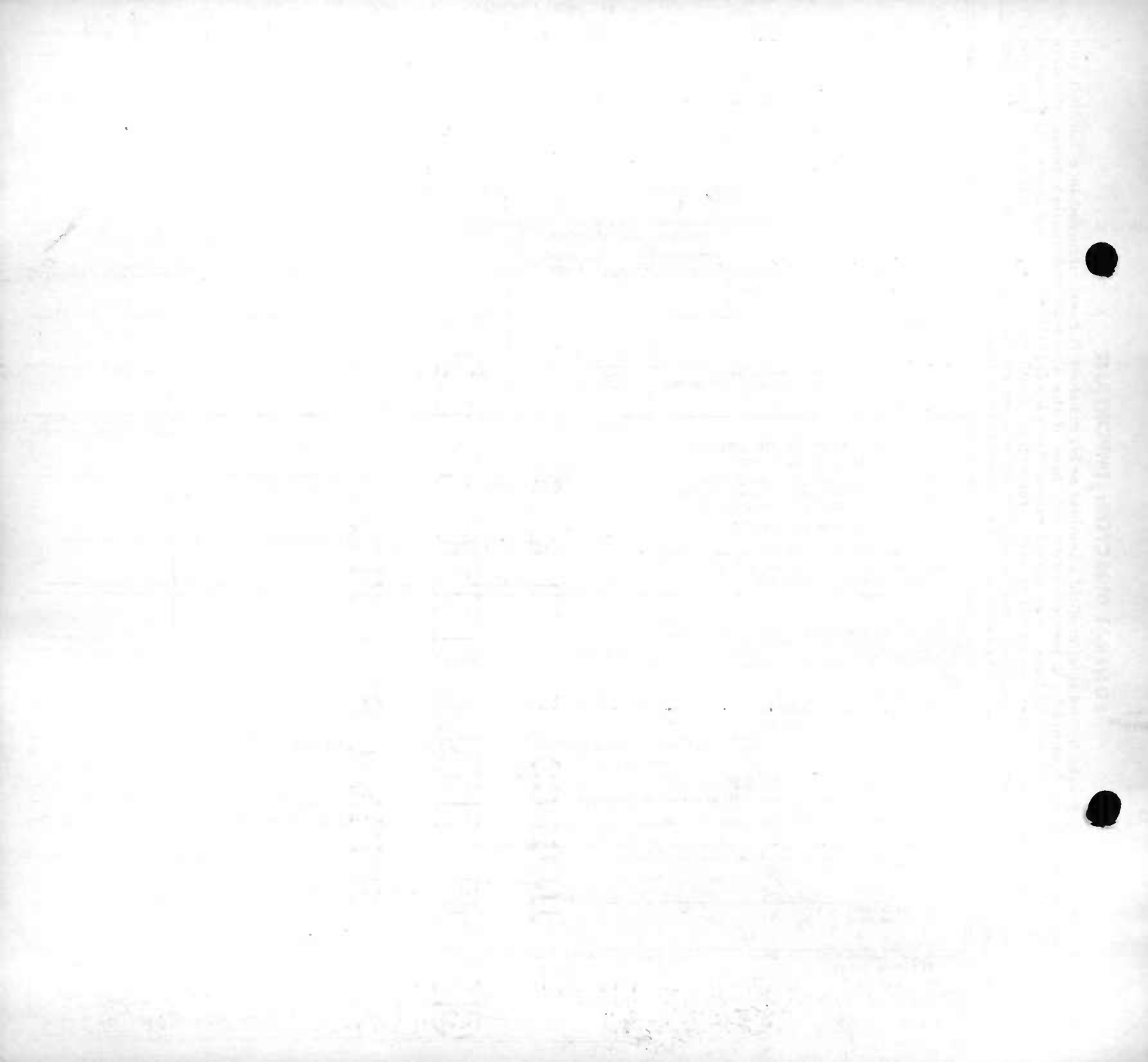
Baltimore City Health Department				REG. NO. 71 3778	
BIRTH NO. S-163		71 3778		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELNORA E. SEIFERT			2. DATE AND HOUR OF DEATH 18-April-71 8:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 876 Wash Blvd.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-5-1915		9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME Wideman			14. MOTHER'S MAIDEN NAME Ester Bradley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Reed's So. Balto. Gen Hosp.
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Embolus				2 hrs	
(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD = Arrhythmia				2 days	
(C) Pulmonary Emboli				3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Ulcerative Colitis				8 yrs.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 16 April 19 71 to 18-April 19 71 that (I) (we) last saw the deceased alive on 18-April 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard E. Fisher M.D.				23B. DATE SIGNED 18-April-71	
23C. PHYSICIAN'S NAME (Type) Richard E. Fisher M.D.				23D. ADDRESS South Baltimore Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-71		24C. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 19 1971 25B. NAME OF REGISTRAR J. E. Fisher			
25C. FUNERAL DIRECTOR McCully				ADDRESS 2237 Latapsec Ave. Md. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

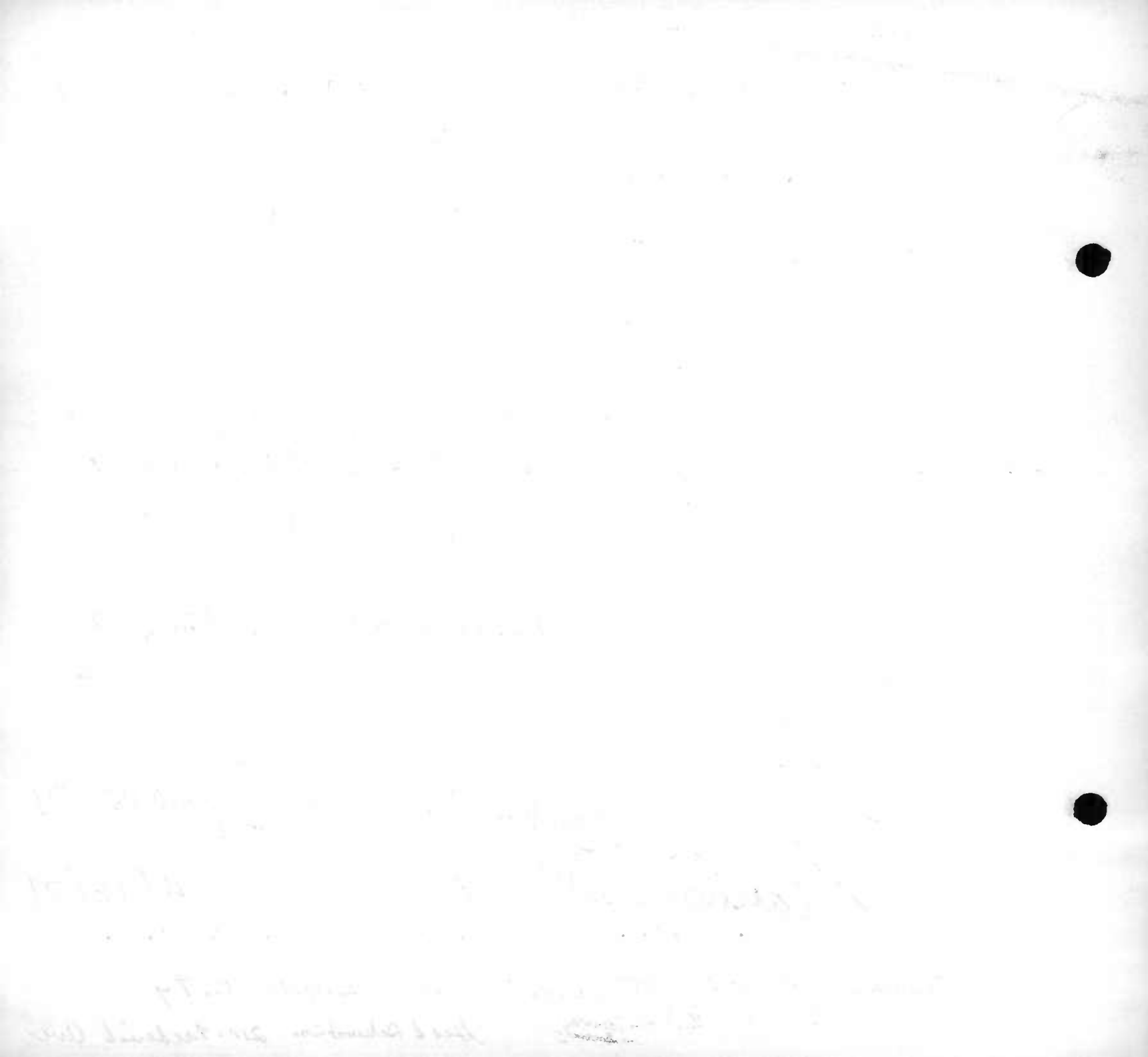
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3779</u>		
D-630 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>DeHart, Posey D.</u>		2. DATE AND HOUR OF DEATH <u>4-17-71</u> <u>9¹⁵</u> P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2534</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3705 6th St.</u>				
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-04</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: <u> </u> Days: <u> </u>	If Under 24 Hrs. Hours: <u> </u> Min: <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Martin Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Sparrow Rufus DeHart</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Hayden</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>3705 6th St - family</u>		ADDRESS <u> </u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMPHYSEMA</u> (B) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> (C) <u>DIABETES MELLITUS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>2 HRS</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION <u>4/6/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ARTERIAL INSUFFICIENCY</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX: <u> </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>		
22. I certify that (I) (this hospital) attended the deceased from <u>3/20/71</u> 19<u> </u> to <u>4/17</u> 19<u>71</u> that (I) (we) last saw the deceased alive on <u>4/17</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Coleman</u>				23B. DATE SIGNED <u>4/17/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>COLEMAN C. HEINRITZ MD</u>		23D. ADDRESS <u>1916 BELAIR ROAD, FALLS CH., MD.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-21-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>		
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1971</u>				
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>McCully, 237 Patapsco Ave 21225</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

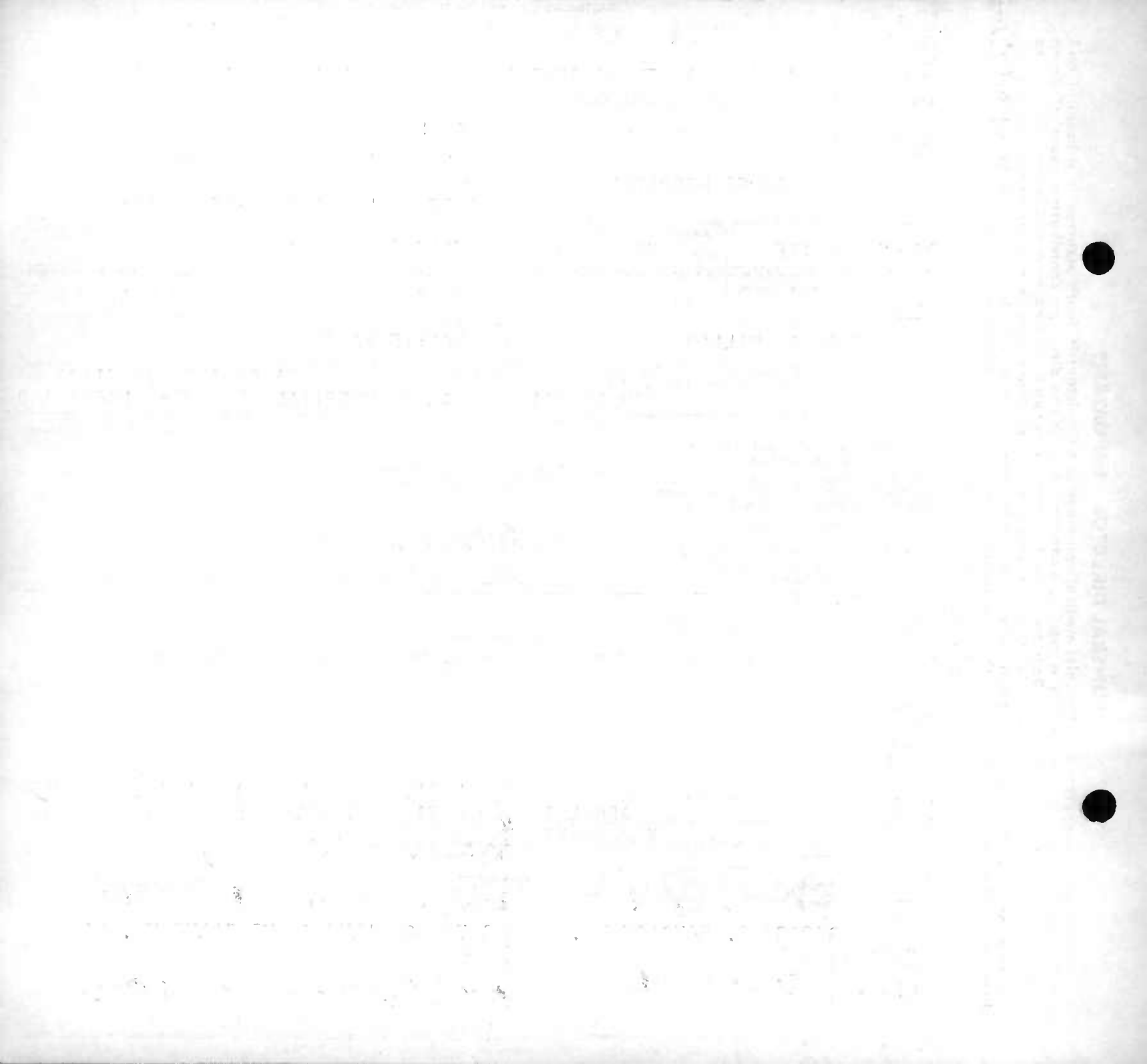
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3780	
CERTIFICATE OF DEATH					
BIRTH NO. P-412		71 3780			
1. NAME OF DECEASED (Type or Print) PHILLIPS, Gertrude			2. DATE AND HOUR OF DEATH April 15, 1971 4:10 AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1005		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2506 Wilkens Avenue		
5. SEX F	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/94	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Pheonix Pad Co.		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A			
14. MOTHER'S MAIDEN NAME Eva Iffer					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-85678		17. INFORMANT Floyd W. Phillips ADDRESS 2306 Wilkens Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute MI			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Essential Hypertension?					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to April 15, 1971 and that (I) (we) last saw the deceased alive on March 24, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl I. Pass				23B. DATE SIGNED 4/16/71	
23C. PHYSICIAN'S NAME (Type) EARL I. PASS, M.D.				23D. ADDRESS 4001 Wilkens Avenue, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-71		24C. NAME OF CEMETERY or CREMATORY Mt Olivet Cem	
24D. LOCATION (City, town, or county) (State) Baltimore City					
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Saylor, M.D.		25C. FUNERAL DIRECTOR Leslie Schwaner ADDRESS 2101 Frederick Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3781	
8-536 71 3781		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)	
		SNYDER, KATHERINE GENEVA	
2. DATE AND HOUR OF DEATH		APRIL 16, 1971 11.45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY 302	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1037 W. LOMBARD STREET 21223	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/24/08
		9. AGE (In years last birthday) 62	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME THOMAS A. MILLER		14. MOTHER'S MAIDEN NAME HATTIE YATES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 295229211	
		17. INFORMANT CATON AVENUES 21229 ST AGNES HOSPITAL RECORDS-WILKENS AND	
18. 427.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE hypoxia DUE TO, OR AS A CONSEQUENCE OF: (B) respiratory depression DUE TO, OR AS A CONSEQUENCE OF: (C) Cerebral Anoxia 2° to initial CHF	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 11, 19 71 to APRIL 16, 19 71 that (X) (we) last saw the deceased alive on APRIL 16, 19 71 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XX) (not) view the body after death.			
23A. SIGNATURE George S. Patrick		23B. DATE SIGNED 4/16/71	
23C. PHYSICIAN'S NAME (Type) GEORGE S. PATRICK MD.		23D. ADDRESS CATON & WILKENS AVE BALTO MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem Pl		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Charles E. ...	
25C. FUNERAL DIRECTOR George S. Patrick, Inc.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>71 3782</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Perkins, Willie		March 7, 1971 6:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
		Maryland		402	
90 Hilton Nursing Home 3313 Poplar Street Balto., Md. 21216		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		3313 POPLAR ST			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/25/14	56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Unknown		Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		237-12-3515			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I		Carcinoma right lung with metastasis			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 28, 1971 to March 6, 1971 that (I) last saw the deceased alive on 2-2-1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		3/8/71	
		23D. ADDRESS			
Dr. Barbu Calin, M.D.		831 Poplar Grove Street, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR	
		4-14-71		ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 19 1971		Robert E. Baker		UNIVERSITY MEDICAL SCHOOL	
MORTUARY SERVICE - BCHO					

734 W. Fayette St.

1		71 3783		BALTIMORE CITY HEALTH DEPARTMENT	
L-200		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 3783	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) ARTHUR D. LEWIS			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2129 Mt. Holly St.			3. DATE PRONOUNCED DEAD Month Day Year Hour 3 26 1971 10:50 a.m.		
6. SEX male			5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1509		
7. RACE negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH		10. AGE (In years last birthday) 68		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 2129 Mt. Holly St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			14B. KIND OF BUSINESS OR INDUSTRY		
15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			17. SOCIAL SECURITY NO.		
18. INFORMANT			ADDRESS		
19. 412.4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21. AUTOPSY? (Yes or No) no					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 3/26/71					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-15-71		24C. NAME OF CEMETERY AND LOCATION (City, State or foreign country) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD					

60-1

WALLER

254



11-12-71

AMERICAN LIBRARY OF CONGRESS
1000 MARYLAND AVENUE
WASHINGTON, D.C. 20540

1

B-430

71 3784

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3784

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Belt		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 2 8 71 5:30 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 552 Dolphin St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 2 8 71 5:30 p.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702	
9. DATE OF BIRTH		10. AGE (In years last birthday) 54	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type) Deputy Chief Medical Examiner DATE SIGNED: 2/9/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-15-71	
24C. NAME OF CEMETERY		24D. NAME OF REGISTRAR	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BOWEN

Medical Examination Certificate

NAME: _____

DATE: _____

TIME: _____

PLACE: _____

BY: _____

Signature: _____

Stamp: _____

VALLEY COUNTY

1911

1000

1

R-525

71 3785

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3785

1. NAME OF DECEASED (Type or Print) ALFRED C. RANSOM		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 713 Newington Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour February 24, 1971 5:10 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1302	
9. DATE OF BIRTH		10. AGE (in years last birthday) 50	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 4/12/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED February 25, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-15-71	
24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCD

M-535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3786

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN C. MUNDEN

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 8, 1971

6:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

203

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1600 Lancaster Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/9/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR INTERMENT PLACE

24D. NAME OF FUNERAL HOME OR ADDRESS

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1971

25B. NAME OF REGISTRAR

25C. NAME OF REGISTRAR

25D. NAME OF REGISTRAR

25E. NAME OF REGISTRAR

25F. NAME OF REGISTRAR

25G. NAME OF REGISTRAR

25H. NAME OF REGISTRAR

25I. NAME OF REGISTRAR

25J. NAME OF REGISTRAR

25K. NAME OF REGISTRAR

25L. NAME OF REGISTRAR

25M. NAME OF REGISTRAR

25N. NAME OF REGISTRAR

25O. NAME OF REGISTRAR

25P. NAME OF REGISTRAR

25Q. NAME OF REGISTRAR

25R. NAME OF REGISTRAR

25S. NAME OF REGISTRAR

25T. NAME OF REGISTRAR

25U. NAME OF REGISTRAR

25V. NAME OF REGISTRAR

25W. NAME OF REGISTRAR

25X. NAME OF REGISTRAR

25Y. NAME OF REGISTRAR

25Z. NAME OF REGISTRAR

25AA. NAME OF REGISTRAR

25AB. NAME OF REGISTRAR

25AC. NAME OF REGISTRAR

25AD. NAME OF REGISTRAR

25AE. NAME OF REGISTRAR

25AF. NAME OF REGISTRAR

25AG. NAME OF REGISTRAR

25AH. NAME OF REGISTRAR

25AI. NAME OF REGISTRAR

25AJ. NAME OF REGISTRAR

25AK. NAME OF REGISTRAR

25AL. NAME OF REGISTRAR

25AM. NAME OF REGISTRAR

25AN. NAME OF REGISTRAR

25AO. NAME OF REGISTRAR

25AP. NAME OF REGISTRAR

25AQ. NAME OF REGISTRAR

25AR. NAME OF REGISTRAR

25AS. NAME OF REGISTRAR

25AT. NAME OF REGISTRAR

25AU. NAME OF REGISTRAR

25AV. NAME OF REGISTRAR

25AW. NAME OF REGISTRAR

25AX. NAME OF REGISTRAR

25AY. NAME OF REGISTRAR

25AZ. NAME OF REGISTRAR

25BA. NAME OF REGISTRAR

25BB. NAME OF REGISTRAR

25BC. NAME OF REGISTRAR

25BD. NAME OF REGISTRAR

25BE. NAME OF REGISTRAR

25BF. NAME OF REGISTRAR

25BG. NAME OF REGISTRAR

25BH. NAME OF REGISTRAR

25BI. NAME OF REGISTRAR

25BJ. NAME OF REGISTRAR

25BK. NAME OF REGISTRAR

25BL. NAME OF REGISTRAR

25BM. NAME OF REGISTRAR

25BN. NAME OF REGISTRAR

25BO. NAME OF REGISTRAR

25BP. NAME OF REGISTRAR

25BQ. NAME OF REGISTRAR

25BR. NAME OF REGISTRAR

25BS. NAME OF REGISTRAR

25BT. NAME OF REGISTRAR

25BU. NAME OF REGISTRAR

25BV. NAME OF REGISTRAR

25BW. NAME OF REGISTRAR

25BX. NAME OF REGISTRAR

25BY. NAME OF REGISTRAR

25BZ. NAME OF REGISTRAR

25CA. NAME OF REGISTRAR

25CB. NAME OF REGISTRAR

25CC. NAME OF REGISTRAR

25CD. NAME OF REGISTRAR

25CE. NAME OF REGISTRAR

25CF. NAME OF REGISTRAR

25CG. NAME OF REGISTRAR

25CH. NAME OF REGISTRAR

25CI. NAME OF REGISTRAR

25CJ. NAME OF REGISTRAR

25CK. NAME OF REGISTRAR

25CL. NAME OF REGISTRAR

25CM. NAME OF REGISTRAR

25CN. NAME OF REGISTRAR

25CO. NAME OF REGISTRAR

25CP. NAME OF REGISTRAR

25CQ. NAME OF REGISTRAR

25CR. NAME OF REGISTRAR

25CS. NAME OF REGISTRAR

25CT. NAME OF REGISTRAR

25CU. NAME OF REGISTRAR

25CV. NAME OF REGISTRAR

25CW. NAME OF REGISTRAR

25CX. NAME OF REGISTRAR

25CY. NAME OF REGISTRAR

25CZ. NAME OF REGISTRAR

25DA. NAME OF REGISTRAR

25DB. NAME OF REGISTRAR

25DC. NAME OF REGISTRAR

25DD. NAME OF REGISTRAR

25DE. NAME OF REGISTRAR

25DF. NAME OF REGISTRAR

25DG. NAME OF REGISTRAR

25DH. NAME OF REGISTRAR

25DI. NAME OF REGISTRAR

25DJ. NAME OF REGISTRAR

25DK. NAME OF REGISTRAR

25DL. NAME OF REGISTRAR

25DM. NAME OF REGISTRAR

25DN. NAME OF REGISTRAR

25DO. NAME OF REGISTRAR

25DP. NAME OF REGISTRAR

25DQ. NAME OF REGISTRAR

25DR. NAME OF REGISTRAR

25DS. NAME OF REGISTRAR

25DT. NAME OF REGISTRAR

25DU. NAME OF REGISTRAR

25DV. NAME OF REGISTRAR

25DW. NAME OF REGISTRAR

25DX. NAME OF REGISTRAR

25DY. NAME OF REGISTRAR

25DZ. NAME OF REGISTRAR

25EA. NAME OF REGISTRAR

25EB. NAME OF REGISTRAR

25EC. NAME OF REGISTRAR

25ED. NAME OF REGISTRAR

25EE. NAME OF REGISTRAR

25EF. NAME OF REGISTRAR

25EG. NAME OF REGISTRAR

25EH. NAME OF REGISTRAR

25EI. NAME OF REGISTRAR

25EJ. NAME OF REGISTRAR

25EK. NAME OF REGISTRAR

25EL. NAME OF REGISTRAR

25EM. NAME OF REGISTRAR

25EN. NAME OF REGISTRAR

25EO. NAME OF REGISTRAR

25EP. NAME OF REGISTRAR

25EQ. NAME OF REGISTRAR

25ER. NAME OF REGISTRAR

25ES. NAME OF REGISTRAR

25ET. NAME OF REGISTRAR

25EU. NAME OF REGISTRAR

25EV. NAME OF REGISTRAR

25EW. NAME OF REGISTRAR

25EX. NAME OF REGISTRAR

25EY. NAME OF REGISTRAR

25EZ. NAME OF REGISTRAR

25FA. NAME OF REGISTRAR

25FB. NAME OF REGISTRAR

25FC. NAME OF REGISTRAR

25FD. NAME OF REGISTRAR

25FE. NAME OF REGISTRAR

25FF. NAME OF REGISTRAR

25FG. NAME OF REGISTRAR

25FH. NAME OF REGISTRAR

25FI. NAME OF REGISTRAR

25FJ. NAME OF REGISTRAR

25FK. NAME OF REGISTRAR

25FL. NAME OF REGISTRAR

25FM. NAME OF REGISTRAR

25FN. NAME OF REGISTRAR

25FO. NAME OF REGISTRAR

25FP. NAME OF REGISTRAR

25FQ. NAME OF REGISTRAR

25FR. NAME OF REGISTRAR

25FS. NAME OF REGISTRAR

25FT. NAME OF REGISTRAR

25FU. NAME OF REGISTRAR

25FV. NAME OF REGISTRAR

25FW. NAME OF REGISTRAR

25FX. NAME OF REGISTRAR

25FY. NAME OF REGISTRAR

25FZ. NAME OF REGISTRAR

25GA. NAME OF REGISTRAR

25GB. NAME OF REGISTRAR

25GC. NAME OF REGISTRAR

25GD. NAME OF REGISTRAR

25GE. NAME OF REGISTRAR

25GF. NAME OF REGISTRAR

25GG. NAME OF REGISTRAR

25GH. NAME OF REGISTRAR

25GI. NAME OF REGISTRAR

25GJ. NAME OF REGISTRAR

25GK. NAME OF REGISTRAR

25GL. NAME OF REGISTRAR

25GM. NAME OF REGISTRAR

25GN. NAME OF REGISTRAR

25GO. NAME OF REGISTRAR

25GP. NAME OF REGISTRAR

25GQ. NAME OF REGISTRAR

25GR. NAME OF REGISTRAR

25GS. NAME OF REGISTRAR

25GT. NAME OF REGISTRAR

25GU. NAME OF REGISTRAR

25GV. NAME OF REGISTRAR

25GW. NAME OF REGISTRAR

25GX. NAME OF REGISTRAR

25GY. NAME OF REGISTRAR

25GZ. NAME OF REGISTRAR

25HA. NAME OF REGISTRAR

25HB. NAME OF REGISTRAR

25HC. NAME OF REGISTRAR

25HD. NAME OF REGISTRAR

25HE. NAME OF REGISTRAR

25HF. NAME OF REGISTRAR

2

UNIVERSITY OF MICHIGAN
LIBRARY

N-420

71 3787

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

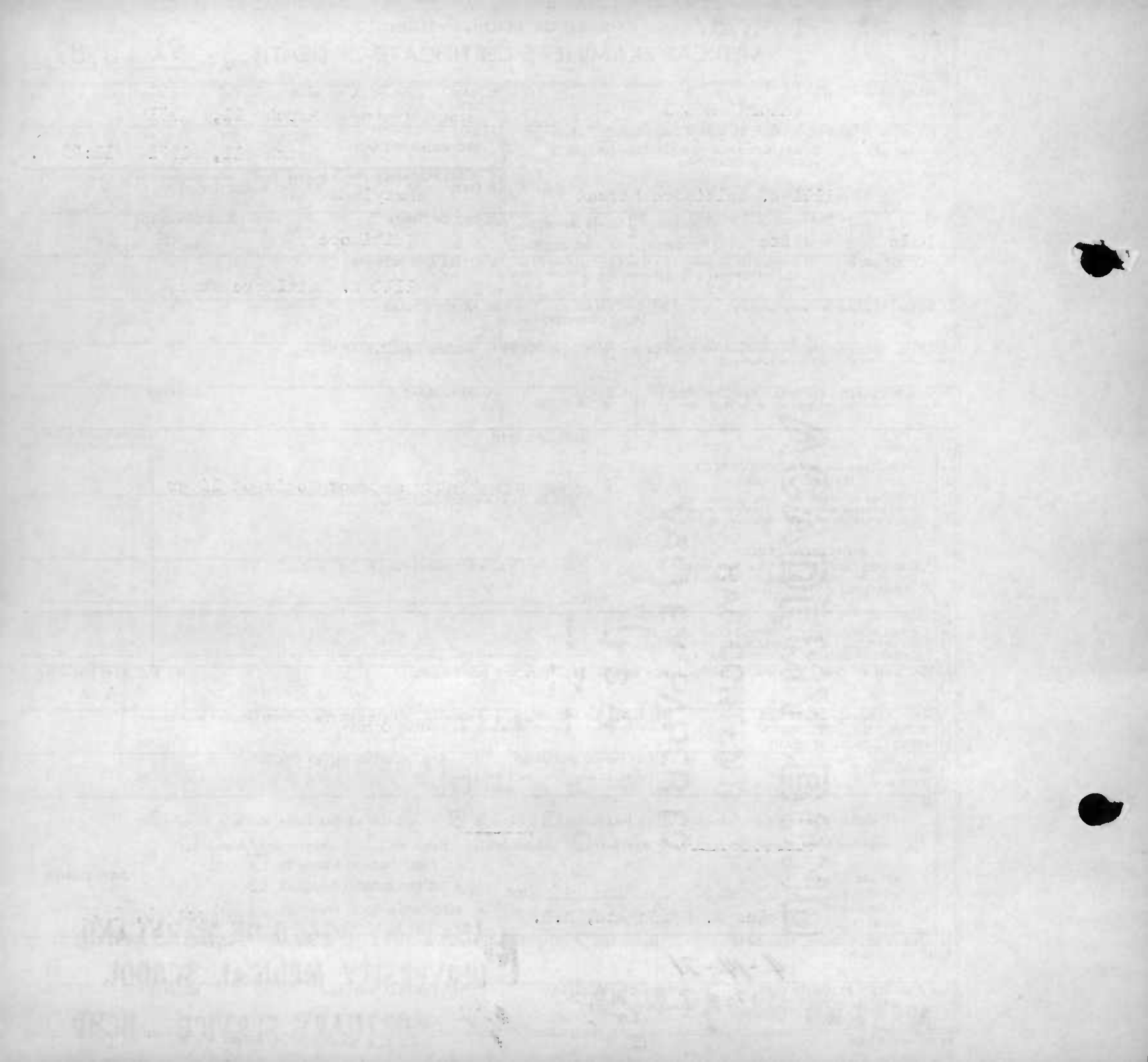
REG. NO. 71 3787

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RALPH NOLES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 11 Year 1971 Hour M. 	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1111 E. Baltimore Street		3. DATE PRONOUNCED DEAD Month March Day 11 Year 1971 Hour 11:25 A. M. 	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 302	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 49 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 571.8 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		DATE SIGNED March 11, 1971	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> K-500 71 3788 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3788	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Herbert Keene		2. DATE AND HOUR OF DEATH 4-14-71 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Pleasant Manor Convalescent Care 4615 Park Heights Ave Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1506 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 26 Herbert St., Balt. Md.			
5. SEX Male 6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-06	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Nav & Z		16. SOCIAL SECURITY NO. 214-03497		17. INFORMANT Hattie Gainer, 26 Herbert Street	
18. 168.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ca of lung(RT)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). SECONDARY ANEMIA		19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPT (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 7 19 71 to April 14 19 71 , that (I) (we) last saw the deceased alive on April 8 19 71 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Larry T. Ingle, M.D.		23B. DATE SIGNED April 14, 1971		23C. PHYSICIAN'S NAME (Type) Larry T. Ingle, M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-71		24C. NAME OF CEMETERY OR CREMATORY mt Calvary Cem.	
24D. LOCATION (City, town, or county) Baltimore Md		24E. FUNERAL DIRECTOR Sharon D. Wilson		24F. ADDRESS 1917 N. Belton	
25A. DATE REC'D BY HEALTH DEPT APR 19 1971		25B. NAME OF REGISTRAR Reid E. Taylor		25C. NAME OF REGISTRAR Sharon D. Wilson	

House NO. does NOT exit. N.H.
says zip is 21216, therefore
coded to that CT.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				71 3789
BIRTH NO. [REDACTED]		REG. NO. [REDACTED]		
1. NAME OF DECEASED (Type or Print) CHARLES UNGER		2. DATE AND HOUR OF DEATH 4/16/71 4:55 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital 66 Lutheran Hosp. of Md.		A. STATE Md. B. COUNTY Baltimore		
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 812 Braeside Road		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-05	9. AGE (in years, last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffer		10B. KIND OF BUSINESS OR INDUSTRY Balto Transit		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME Late Frank B. Unger		14. MOTHER'S MAIDEN NAME Late Stella M.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-1468a		17. INFORMANT Mr. Louis Under, 812 Braeside Road, 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One month
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 4/16/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4/16/71		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/13/71 to 4/16/71 and that (I) (we) lost saw the deceased alive on 4/16/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 4.16.71		
23C. PHYSICIAN'S NAME (Type) C. GAKUBA		23D. ADDRESS Lutheran Hosp. 730 ASHBURTON ST. Balto. 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/20/71	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave, 21228



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

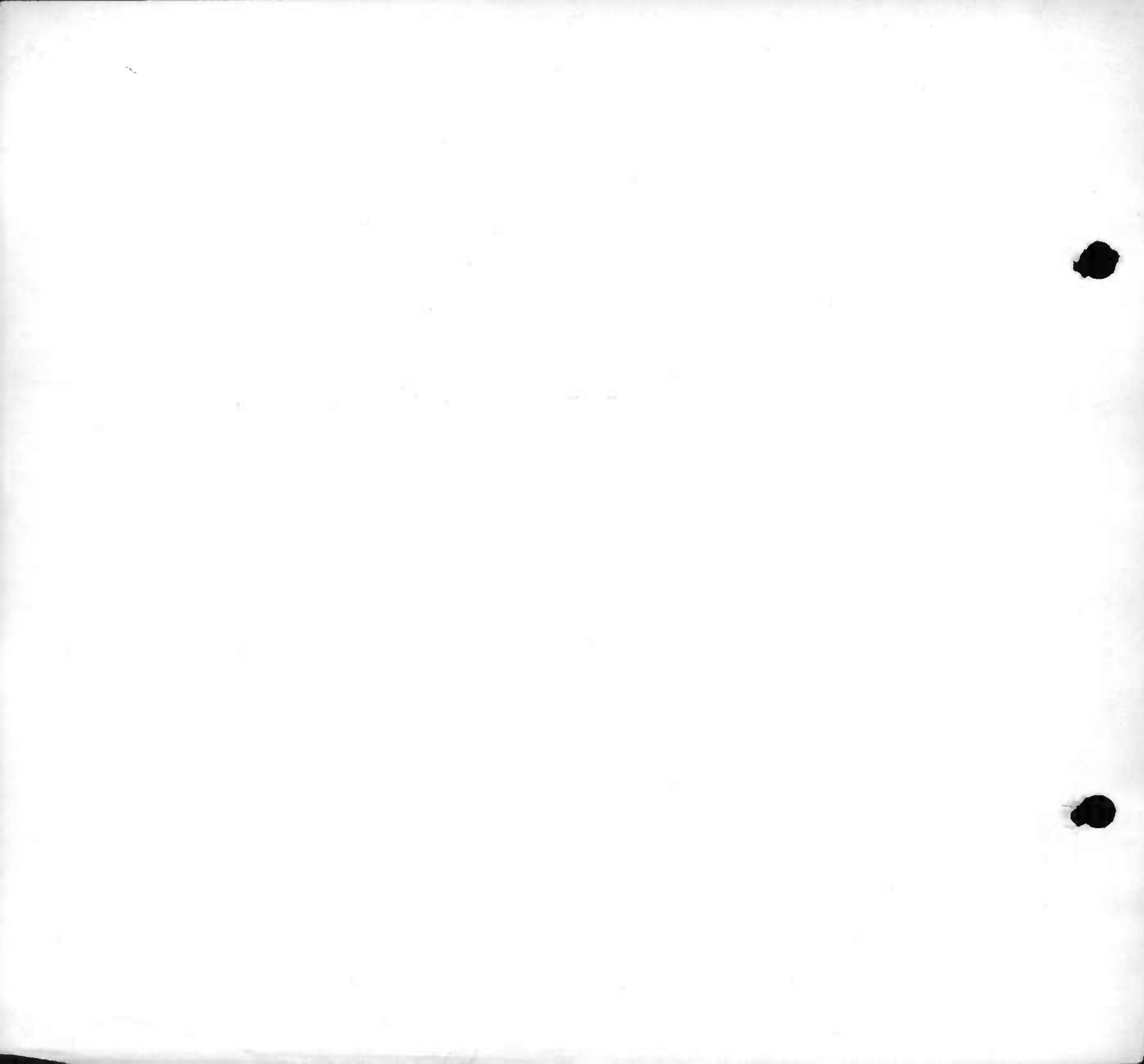
T-652 71 3780		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 3780	
1. NAME OF DECEASED (Type or Print) TRINGALI PHILIP			2. DATE AND HOUR OF DEATH 4/17/71 11:30 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BONSECOURS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY HOWARD CO. C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5114 E. DURHAM RD.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/01	9. AGE (in years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOLLINS MARKET		10B. KIND OF BUSINESS OR INDUSTRY Z	11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME PETER TRINGALI			14. MOTHER'S MAIDEN NAME NATALIE Z		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 216 32 9822	17. INFORMANT PT. S. CHART ADDRESS		
18. 25071 CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus with coma					days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) acute pyelonephritis					weeks
Coronary Arteriosclerosis					years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ferdous Kazemi M.D. DEGREE				23B. DATE SIGNED 4-17-71	
23C. PHYSICIAN'S NAME (Type) FERDOUS KAZEMI DEGREE				23D. ADDRESS BON SECOURS Hospital Baltimore, Md. 21223	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 21 '71		24C. NAME OF CEMETERY OR CREMATORY Crest Lawn	
24D. LOCATION Howard County		24E. LOCATION (City, town, or county) (State) Howard County			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Barbara E. Kelly		25C. FUNERAL DIRECTOR Funeral Home Harry Witzke Ellicott City	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3791</u>	
N-425 71 3791		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Nelson, James J.</u>		2. DATE AND HOUR OF DEATH <u>4/16/71</u> <u>7</u> <u>25</u> <u>AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u> <u>46</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1604</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1906 W. Lanvale St.</u>			
5. SEX <u>M</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-13</u>	9. AGE (in years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disability</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Nelson</u>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-00-9624</u>		17. INFORMANT <u>Mrs M. rie Marshall, Same</u> ADDRESS	
18. <u>41231</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Heart Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS.</u> <u>YEARS.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>PLEURAL EFFUSION, @ side</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YEARS</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> <u>1971</u> to <u>4-16</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>4-16</u> <u>1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Angelita A. Topacio, M.D.</u>		23B. DATE SIGNED <u>4-16-71</u>		23C. PHYSICIAN'S NAME (Type) <u>ANGELIT A. TOPACIO, M.D.</u>	
23D. ADDRESS <u>LUTHERAN HOSP., BALTO. MD 21206</u>		23E. DEGREE <u>DEGREE</u>		23F. DEGREE <u>DEGREE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/20/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Petersburg</u>	
24D. LOCATION <u>Virginia</u>		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT DR. BURNETT 41-48-26 3792 REG. NO. B X WD			
C-434 71 3792		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) HENRY CALDWELL		2. DATE AND HOUR OF DEATH 4/18/71 1:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN PASEDENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER ROUTE 6 Box 1A 5200			
5. SEX M	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY ?	9. AGE (in years last birthday) 74
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Chart ADDRESS
18. 03891 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH RESPIRATORY IMMEDIATE CAUSE RESPIRATORY SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF: WITH SEPTIC SHOCK APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS		19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II	
19A. DATE OF OPERATION 4/17/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/17/71 19 71 to 4/18/71 19 71 that (I) was last saw the deceased alive on 4/18/71 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.			
23A. SIGNATURE Meyer R. Heyman M.D.		23B. DATE SIGNED 4/17/71	
23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/21/71	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Adolphus Halst	
25C. FUNERAL DIRECTOR Adolphus Halst		25D. ADDRESS 1206 W North Ave	

Adolphus Halst and 1206 W North Ave

Mt Auburn Cemetery Baltimore, Md

Burial 4/21/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3793 -	
BIRTH NO. 71 3793		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Ivery Bivins</i>		2. DATE AND HOUR OF DEATH <i>4/16/71 10:25 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1701</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 PROVIDENT HOSPITAL, INC 2600 LIBERTY HEIGHTS AVE. BALTO., MARYLAND 21215</i>		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. RACE <i>COLORED</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>2/3/1900</i>	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) <i>FLORIDA</i>		9. AGE (In years last birthday) <i>71</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220/03/1314</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
17. INFORMANT <i>MRS. ANNIE CARTER SISTER</i>		14. MOTHER'S MAIDEN NAME <i>71 3793</i>		ADDRESS <i>SAME</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>019.01 Severe Congestive Heart Failure due to</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Destructive Airway Disease 5 yrs</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>old Tuberculosis Lung 5 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/14</i> 19 <i>71</i> to <i>4/16</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4/16</i> 19 <i>71</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eljah Saunders</i>		23B. DATE SIGNED <i>4/17/71</i>		23C. PHYSICIAN'S NAME (Type) <i>ELIJAH SAUNDERS</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/21/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 20 1971</i>		25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead 1206 W North Ave</i>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3794</u>	
BIRTH NO. <u>B-650 11 3794</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>BROWN, Harvey W.</u>			2. DATE AND HOUR OF DEATH <u>April 14, 1971</u> <u>5:40 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2301</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> 3900 Loch Raven Blvd Baltimore, Maryland 21218			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>5-19-92</u> 9. AGE (in years last birthday) <u>77</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Ward</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Richard Brown</u>		
14. MOTHER'S MAIDEN NAME <u>Harriett Dorman</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 6-2-18 to 7-2-19</u>		
16. SOCIAL SECURITY NO. <u>215-09-56-73</u>			17. INFORMANT <u>Records</u> ADDRESS <u>VAH, 3900 Loch Raven Blvd., Balto., Md. 21218</u>		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute & chronic renal failure</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Obstructive nephropathy</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Anemia, urinary tract infection, Arteriosclerotic heart disease</u>					
19A. DATE OF OPERATION <u>3/23/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>prostate biopsy</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>February 26</u> 19 <u>71</u> to <u>April 14</u> 19 <u>71</u> and that (1) (we) lost saw the deceased alive on <u>April 14</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature] MD</u>				23B. DATE SIGNED <u>4/15/71</u>	
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS <u>3900 Loch Raven Blvd Balto., Md. 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) _____		24B. DATE <u>4-19-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt AUBURN</u>	
24D. LOCATION (City, town, or county) <u>Balto, Md.</u>		24E. LOCATION (State) _____		24F. LOCATION (Country) _____	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>1 J BROWN</u> ADDRESS <u>123 W MONTGOMERY</u>	

BIRTH NO.		71 3795		BALTIMORE CITY HEALTH DEPARTMENT		71 3795	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) Dorsey Brooks				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 19 71 7:30 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 19 71 7:30 a.m.			
6. SEX male				7. RACE Negro		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1601	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 1/13/1915		10. AGE (In years last birthday) 56		E. STREET AND NUMBER 1137 N. Carey Street			
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Extra Brooks			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mamie Byrd			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 231-12-3333		18. INFORMANT ADDRESS Lellie Brooks - 1137 N. Carey St			
19. CAUSE OF DEATH 450X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Massive pulmonary embolism				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/19/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71		24C. NAME OF CEMETERY or CREMATORY Calvary Baptist Church		24D. LOCATION (City, town, or county) (State) Pancreaster Co. Va.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Earl Gilmore		ADDRESS 1827 W. North Ave	

1/13/1912

Winnipeg
Post Office

no

Winnipeg
Post Office

221-12-2222 (1912) N. C.

Winnipeg 4/13/1912 Post Office
Post Office 4/13/1912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3796

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Carroll B. Samuels		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 16 71 11:00 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A.A. Co. 5200		6. SEX male 7. RACE white 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH May 16, 1930 10. AGE (In years lost birthday) 40		C. CITY OR TOWN Hanover D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Virginia		E. STREET AND NUMBER 97 Chesapeake Mobile Homes	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carroll W. Samuel	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Work		14B. KIND OF BUSINESS OR INDUSTRY Kester Baker	
15. MOTHER'S MAIDEN NAME Lilly Lee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. Unknown		18. INFORMANT Carroll W. Samuel - Father	
19. CAUSE OF DEATH E988X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 22		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? West bound ramp to 176 off of 295		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 16 71 1:00 a.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? pedestrian struck by auto	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type)		DATE SIGNED 4/17/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/71	
24C. NAME OF CEMETERY or CREMATORY Totusky Ch. Cemetery		24D. LOCATION (City, town, or county) (State) Totusky, Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Farrow, M.D.	
25C. FUNERAL DIRECTOR R. R. Ware		ADDRESS Singleton Funeral Home/Glen Burnie, Md.	

2

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 71 3797 CERTIFICATE OF DEATH				REG. NO. 71 3797	
BIRTH NO. <u>W-425</u>			1. NAME OF DECEASED (Type or Print) <u>EVERETT LEROY WILSON</u>		
2. DATE AND HOUR OF DEATH <u>April 14 1971</u>			M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42. Sinai Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>		
C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>5802 Lochlea Road</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 Feb 1903</u>	9. AGE (in years lost birthday) <u>68</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Wilson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Mathews</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219 18 1689</u>		
17. INFORMANT <u>Mabel E. Wilson</u>			ADDRESS <u>same</u>		
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 Minutes</u> <u>Several years.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Samuel E. Proctor</u>			23B. DATE SIGNED <u>4/16/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Samuel E. Proctor</u>			23D. ADDRESS <u>104 West Madison</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>17 Apr 71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Baltimore Co., Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>John E. Jones</u>		25C. FUNERAL DIRECTOR <u>Burges Funeral Home, Baltimore Maryland</u>	
25D. ADDRESS <u>By: [Signature]</u>					

George Thompson
Hypnotism

W. D. D. D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

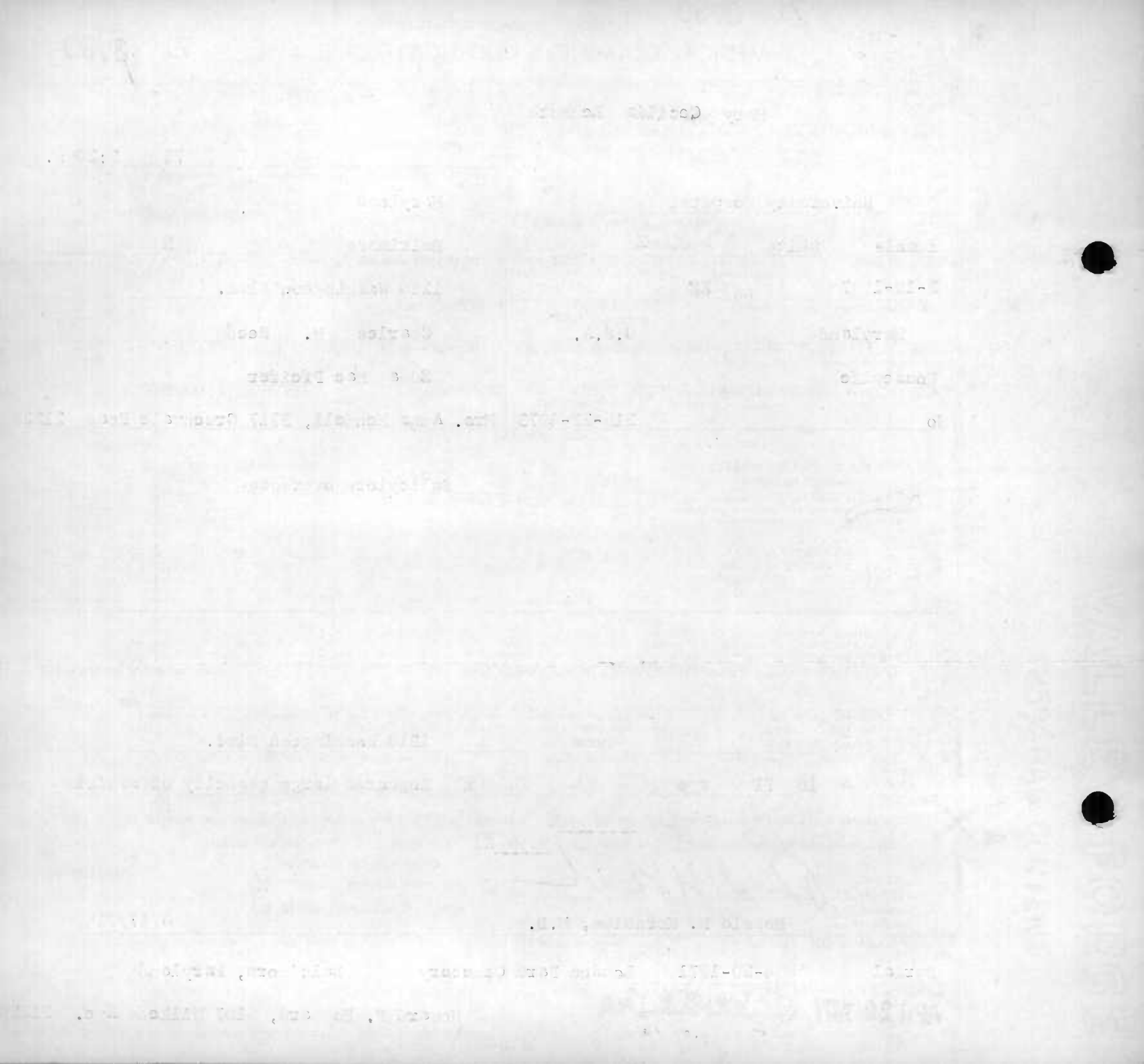
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3798	
G-355 71 3798		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GEORGE F. GUTMANN		April 16, 1971 11:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkins & Caton Avenues 21229		A. STATE Maryland B. COUNTY Baltimore 5300 C. CITY OR TOWN Halethorpe D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1811 Park Avenue 21227			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1904	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Field Director American Red Cross		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John J. Gutmann		14. MOTHER'S MAIDEN NAME Minnie A. Mantz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-18-9978		17. INFORMANT Mr. John E. Gutmann, 1823 Mayfield Ave. 21227	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 5 1/2 hrs 2 1/2 hrs	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Coronary Arteriosclerotic Heart Disease		(B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction			
(C) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct 1969 to Apr 16, 1971 that (1) (we) last saw the deceased alive on Oct 15, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce B. Brumbaugh, MD		23B. DATE SIGNED 4/17/71		23C. PHYSICIAN'S NAME (Type) Bruce B. Brumbaugh	
23D. ADDRESS 5609 Main Street, Elkridge, Maryland		23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-1971		24C. NAME OF CEMETERY OR CREMATORY New Moravian Cemetery	
24D. LOCATION Emmaus, Pennsylvania		24E. ADDRESS		24F. ADDRESS	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3799

BIRTH NO.

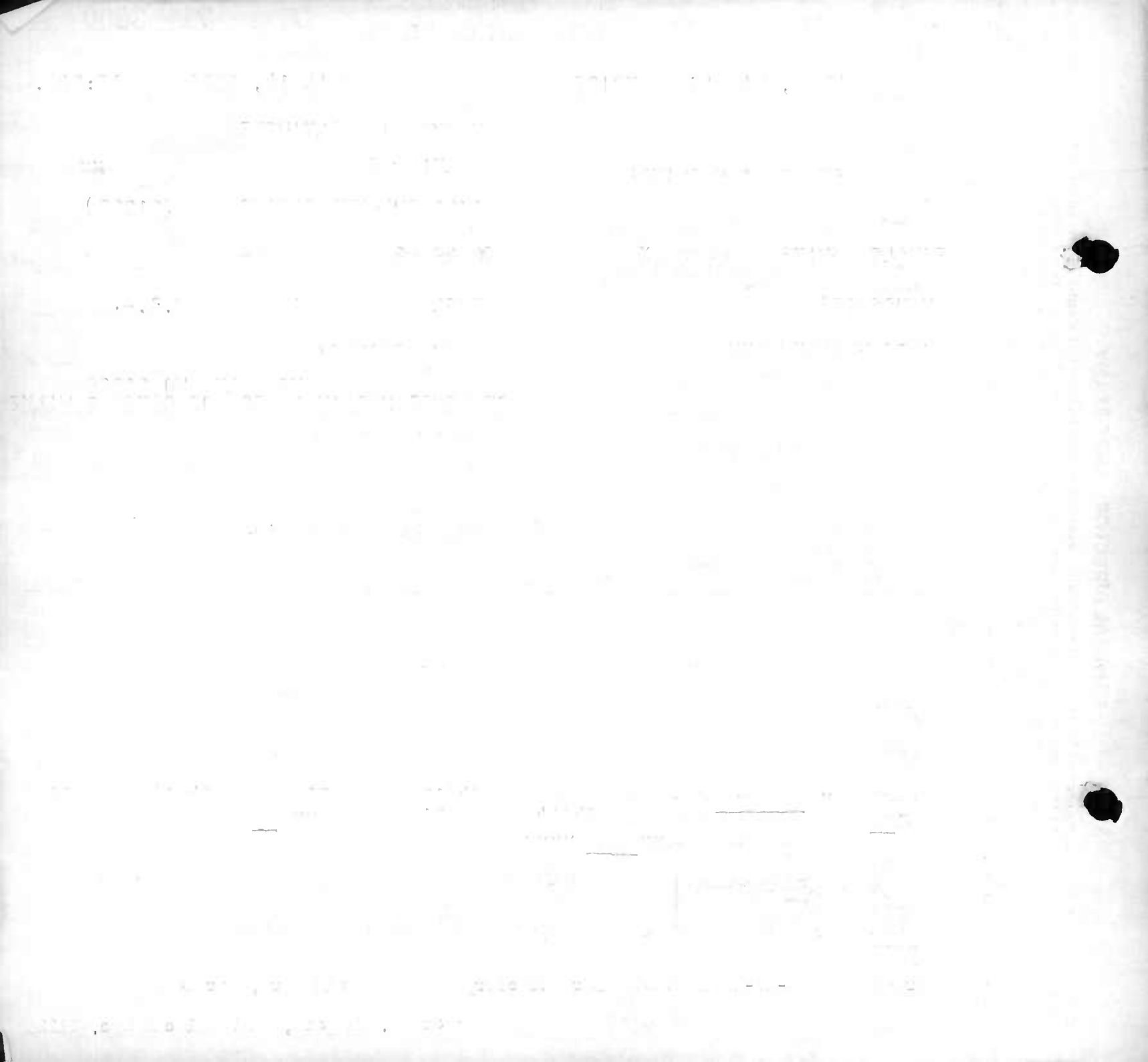
1. NAME OF DECEASED (Type or Print) Mary Cecilia Lehmuth		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 71 2:20 a.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2102		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-19-1907	10. AGE (In years last birthday) 64 83	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles M. Reed	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Edna Mae Pfeifer	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-22-4973	
18. INFORMANT Mrs. Anna Mendell, 3717 Greenvale Road 21229		ADDRESS	
19. CAUSE OF DEATH E95011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Salicylate overdose ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1210 Washington Blvd. 2102		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 16 71 ? p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? ingested large quantity of aspirin	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/17/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-1971	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 3800		CERTIFICATE OF DEATH		REG. NO. 71 3800	
1. NAME OF DECEASED (Type or Print) NAUMAN, MINNIE BEATRICE				2. DATE AND HOUR OF DEATH APRIL 14, 1971 10:23A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND & COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1923 SULPHUR SPRING RD (21227)			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 29 92	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH BARKWORTH			14. MOTHER'S MAIDEN NAME MARY BEECHNER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.			17. INFORMANT AVE BALTO MD 21229 ST AGNES HOSPITAL RECORDS CATON & WILKEN			ADDRESS	
18. 440.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac Failure (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Vascular Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Cardiac Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Vascular Disease (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 30 years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from 04/12 1971 to 04/14 1971 that (X) (we) last saw the deceased alive on 04/14 1971 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.		23A. SIGNATURE Carol Rozentorn 23B. DATE SIGNED 4.14.71	
23C. PHYSICIAN'S NAME (Type) Carol Rozentorn		23D. ADDRESS St. Agnes Htal		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-1971	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave. 21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3801	
BIRTH NO. B-152		71 3801		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FORD BEVINS			2. DATE AND HOUR OF DEATH 4.14.71 1505 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSP			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY BALTO. 5. CITY OR TOWN ARBUTUS 6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7. STREET AND NUMBER 1207 Poplar Ave		
5. SEX M 6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-24 9. AGE (In years last birthday) 47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY Home improvement CORP.		11. BIRTHPLACE (State or foreign country) W. Va. 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Lee Bevins			14. MOTHER'S MAIDEN NAME Vicie Staten		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W II		16. SOCIAL SECURITY NO. 233-32-2238		17. INFORMANT MARGARET BEVINS WIFE SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Branchiopneumonia + Hyperscalcemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Suspected Septicemia (B) DUE TO, OR AS A CONSEQUENCE OF: Lymphoma, genl. (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 9 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-18 19 71 to 4-14 19 71 that (I) (we) last saw the deceased alive on 4-14 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. P. Green MD				23B. DATE SIGNED 4.14.71	
23C. PHYSICIAN'S NAME (Type) DAVID P. GREEN				23D. ADDRESS MARYLAND GEN HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-1971		24C. NAME of CEMETERY or CREMATORY Pleasant Grove Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Bette E. Kelly, R.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3802	
BIRTH NO. R-220		Rev. Hilary J. Rakowski	
1. NAME OF DECEASED (Type or Print) RAKOWSKI, HILARY JOHN		2. DATE AND HOUR OF DEATH 4-15-71 8:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 12290 FOLLY QUARTER RD.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-02
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS		10B. KIND OF BUSINESS OR INDUSTRY Priesthood	9. AGE (In years last birthday) 68
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Rakowski		14. MOTHER'S MAIDEN NAME Stella Milarski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217580532	
		17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4124 I Atherosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 4 5 19 71 to 4 15 19 71 that (X) (we) lost saw the deceased alive on 4 15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Per fecto VALARAO		23B. DATE SIGNED 4-15-71	
23C. PHYSICIAN'S NAME (Type) Per fecto VALARAO MD		23D. ADDRESS Caton & Wilkens Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/71	
24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) (State) Middle Village, Queens, New York	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR George A. Weber	
		25C. FUNERAL DIRECTOR ADDRESS 705 S. Ann St. #21231	

Page 1-

UNITED STATES OF AMERICA

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

TO THE

SENATE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

1899

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

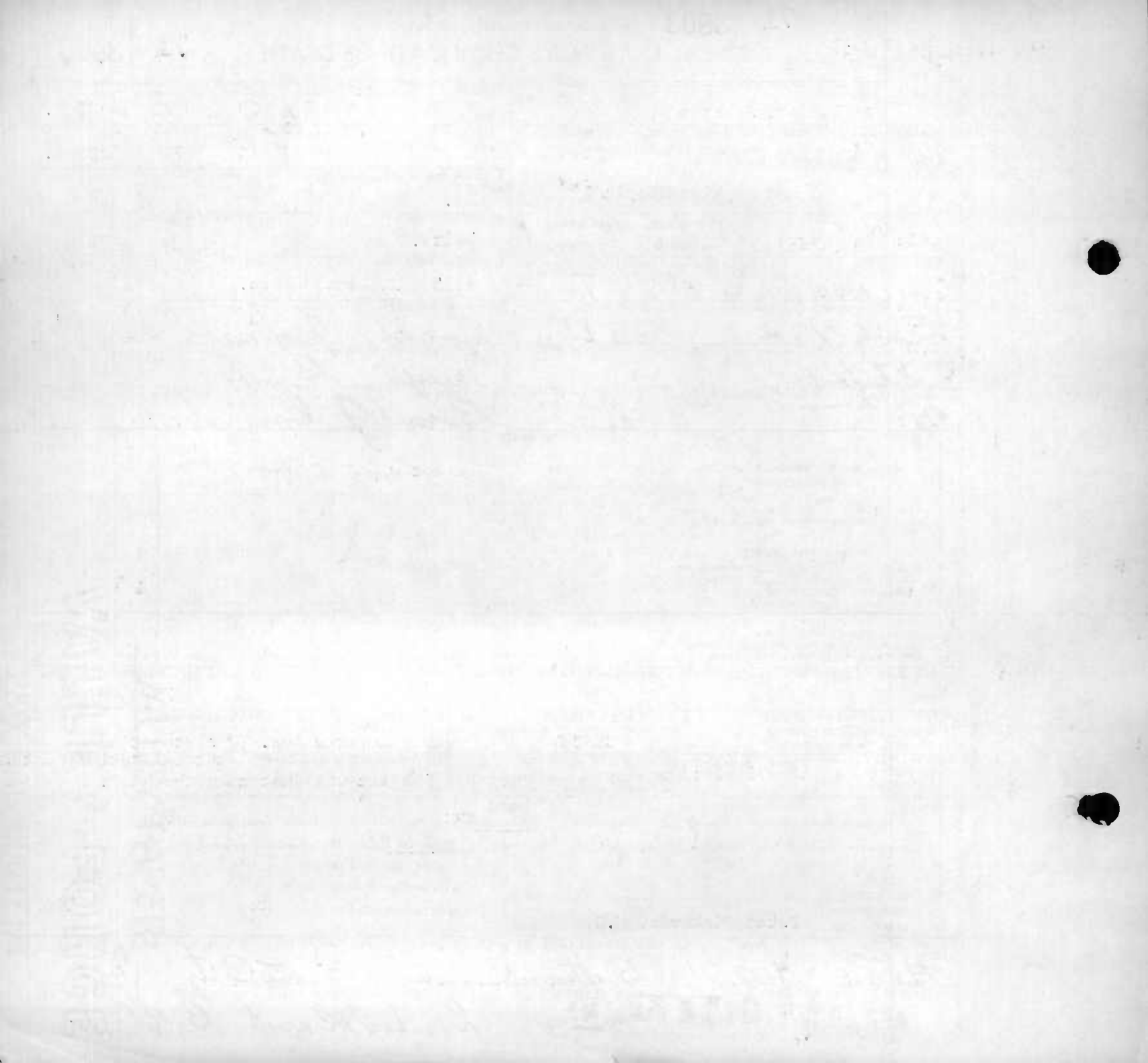
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3803

BIRTH NO.

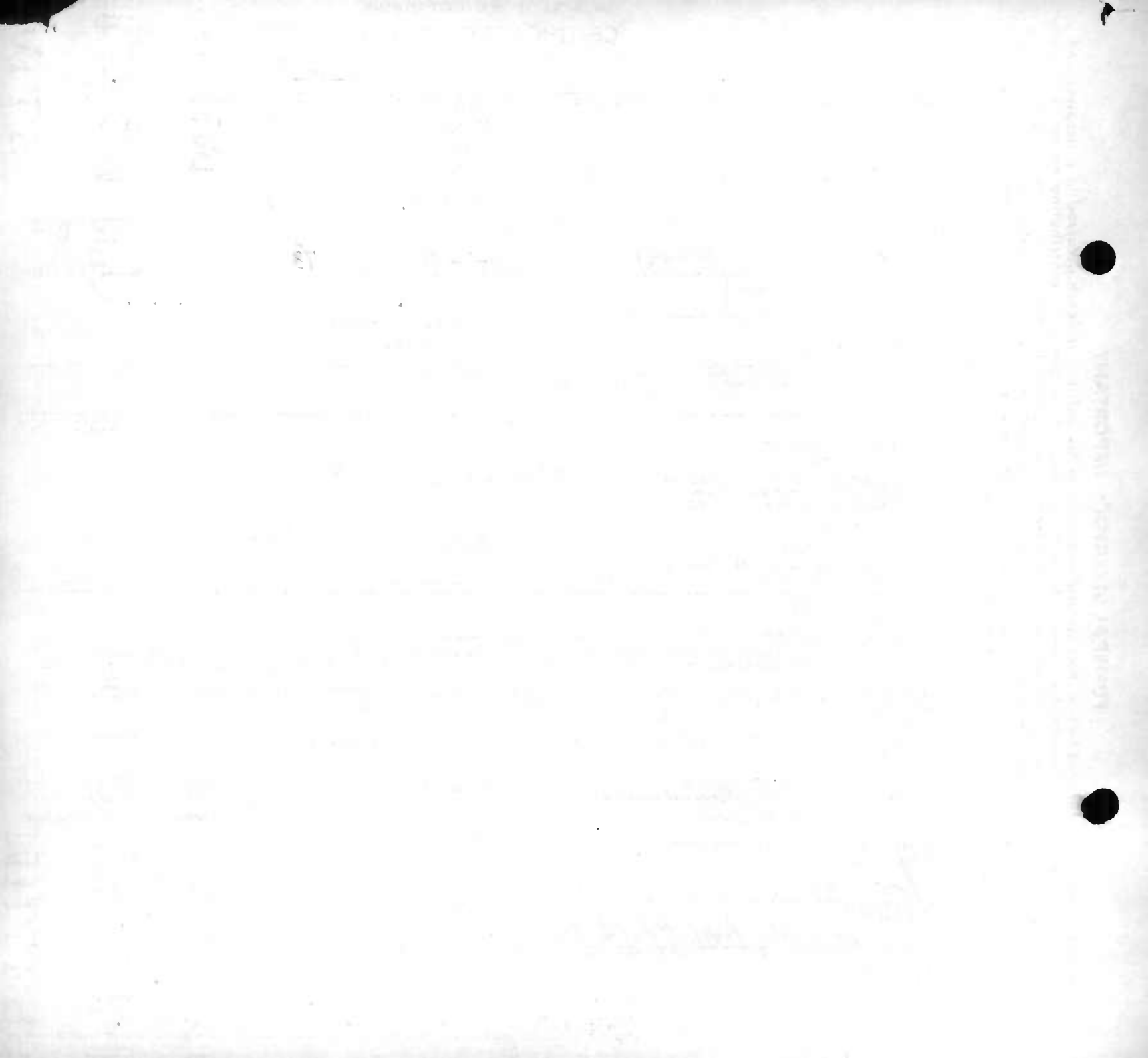
1. NAME OF DECEASED (Type or Print) Bernard Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 19 Year 71 Hour 4:25 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 19 Year 71 Hour 4:25 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 843		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER 1113 N. Kenwood Ave.
9. DATE OF BIRTH 6/11/1954	10. AGE (In years lost birthday) 15	11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.C.
13. FATHER'S NAME Bernard Johnson Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
15. MOTHER'S MAIDEN NAME Marie Burke		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. None		18. INFORMANT Bernard Johnson Sr. 1113 Kenwood Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION 4/22/71	
21. AUTOPSY? (Yes or No) yes (head)		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Industrialization Center	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2519 Luzerne Ave. (Opportunities Industrialization Center)	
22C. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.) 4 18 71 10:30p		22D. HOW DID INJURY OCCUR? Subject was shot in the head.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. INJURY OCCURRED head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) Burial	
24A. DATE REC'D BY HEALTH DEPT. APR 20 1971		24B. DATE 4/22/71	
24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto City Md.	
25A. NAME OF REGISTRAR Robert E. Johnson		25B. FUNERAL DIRECTOR Richard H. Carroll	
25C. ADDRESS Balto, Md.		25D. ADDRESS Balto, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 3804				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 3804	
1. NAME OF DECEASED (Type or Print) <i>Agnes Wilson</i>				2. DATE AND HOUR OF DEATH 4-17-71 6.45 P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY 1502					
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1414 N. FULTON AVENUE					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-98	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN NEAL				14. MOTHER'S MAIDEN NAME Harriett					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Wilson		ADDRESS same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(B) <i>Hypertensive Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/17/71 to 4/17/71 that (I) (we) last saw the deceased alive on 4/17/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>John M. Amatruda MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/17/71			
23C. PHYSICIAN'S NAME (Type) John M. Amatruda MD				23D. ADDRESS 601 N. Broadway, Balt, Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-71		24C. NAME of CEMETERY or CREMATORY Chews Chapel		24D. LOCATION (City, town, or county) (State) Owingsville, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3805</u>	
71 3805				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>SLATER, REBECCA</u>		<u>4-16-71</u> <u>11:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSP.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <u>Baltimore</u>	
				B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1139 STOCKTON ST.</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-96</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>David Phoenix Green</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah Hall</u>	
				ADDRESS <u>1500 Lanvale St. Apt/ 3</u>	
18. <u>4-10-71</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2-19-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-19-71</u> to <u>4-16-71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. 1 DEGREE				23B. DATE SIGNED <u>4-16-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Nasser SAGHAFLI, M.D.</u>		23D. ADDRESS <u>Lutheran Hosp. of Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-20-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> <u>Kelson F.H.</u> ADDRESS <u>1348 Calhoun St.</u>	

EXHIBIT

1-30-42
104112
104112

FATHERMAN
H-27
x

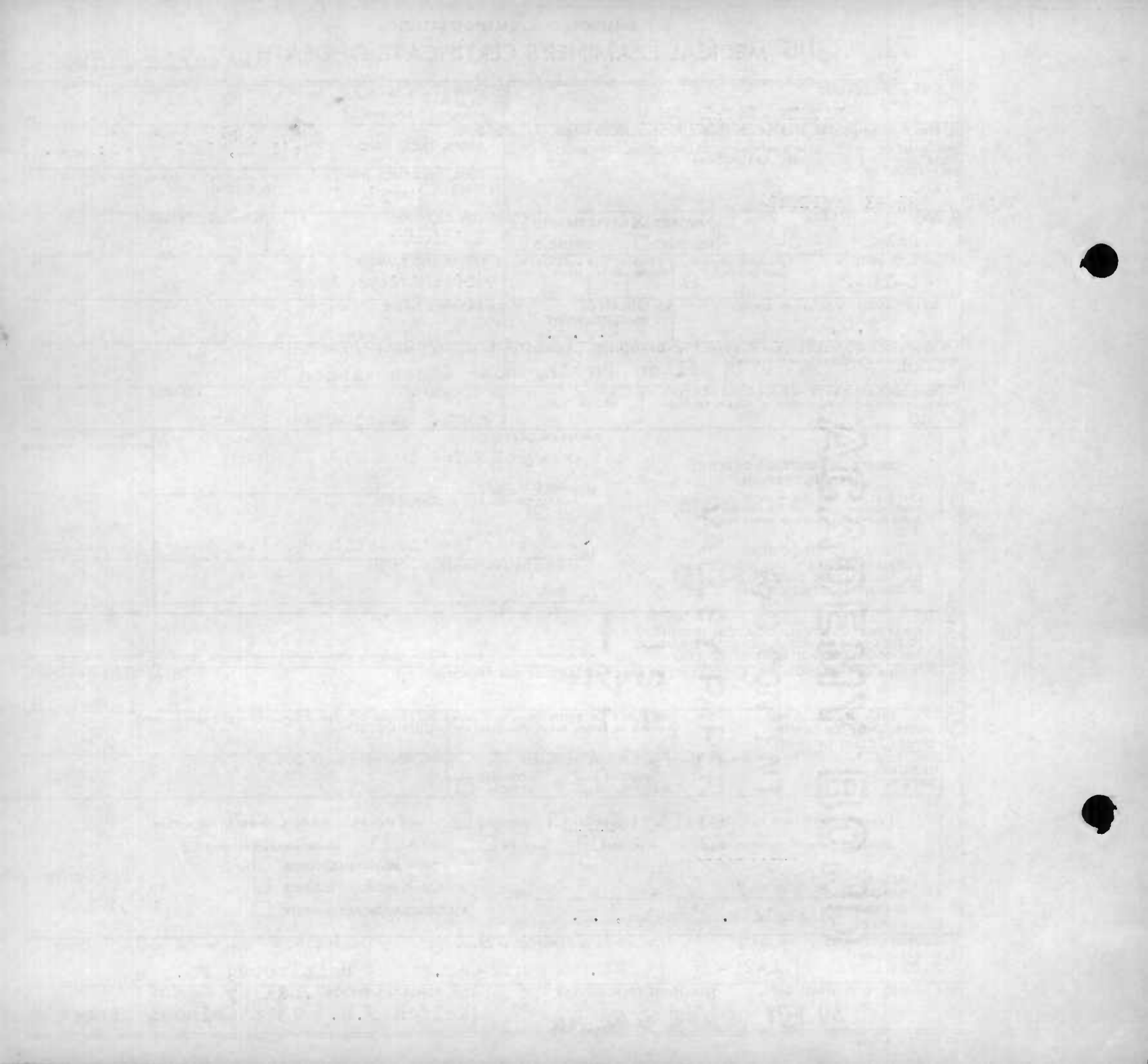


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3806

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MATTIE LATTIMORE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 16, 1971 5:30 A.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1512			
6. SEX Female	7. RACE Negro	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-20-23		10. AGE (In years lost birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		14B. KIND OF BUSINESS OR INDUSTRY Hilton Nursing Home	
13. FATHER'S NAME James Cook		15. MOTHER'S MAIDEN NAME Queen Ranson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Robt. Lattimore		ADDRESS same	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4124 Cerebral Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/16/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-20-71	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971	25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3807

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CLARENCE DAVIS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

48 MARYLAND GENERAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 16, 1971

11:32 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-25-97

10. AGE (In years
lost birthday)

73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2517 Linden Avenue

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

WHICH COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Davis

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Emma Gross

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

Sarah Tyler

ADDRESS

519 Gold St.

19.

E9881X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Aspiration of gastric content

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Blunt force injuries to head

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2517 Linden Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

Unknown

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Found in burning house

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/17/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-22-71

24C. NAME of CEMETERY or CREMATORY

St. Thomas Cem.

24D. LOCATION (City, town, or county)

Randallstown, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 20 1971

25B. NAME OF REGISTRAR

Robert E. Kelly, M.D.

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

Kelson F.H. 1348 Calhoun St.

Letter from M.E.'s office

5-10-71

M.H.

VALLEY OF FORGE

27-000-0000

VS 151-REV. 1/1/68

WALLER 5016E

turnover

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAMIE W. ROBINSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 14, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 526 N. Stricker Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 14, 1971 6:54 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1602	
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov 25-1904		10. AGE (In years, months, days, hours, minutes) 66		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) MANASSAS VIRGINIA		12. CITIZEN OF USA		E. STREET AND NUMBER 526 N. Stricker Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY At Home		13. FATHER'S NAME BENJAMIN HONLEY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME ROSA BROWN	
18. INFORMANT Almond Honley		ADDRESS 1610 W. FRANKLIN ST			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 15, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 4/15/71		24C. NAME OF CEMETERY or CREMATORY W. H. AUBURN	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR William H. Hughes		25D. ADDRESS 638 N. G. 1st St			

ACADEMY FRONT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

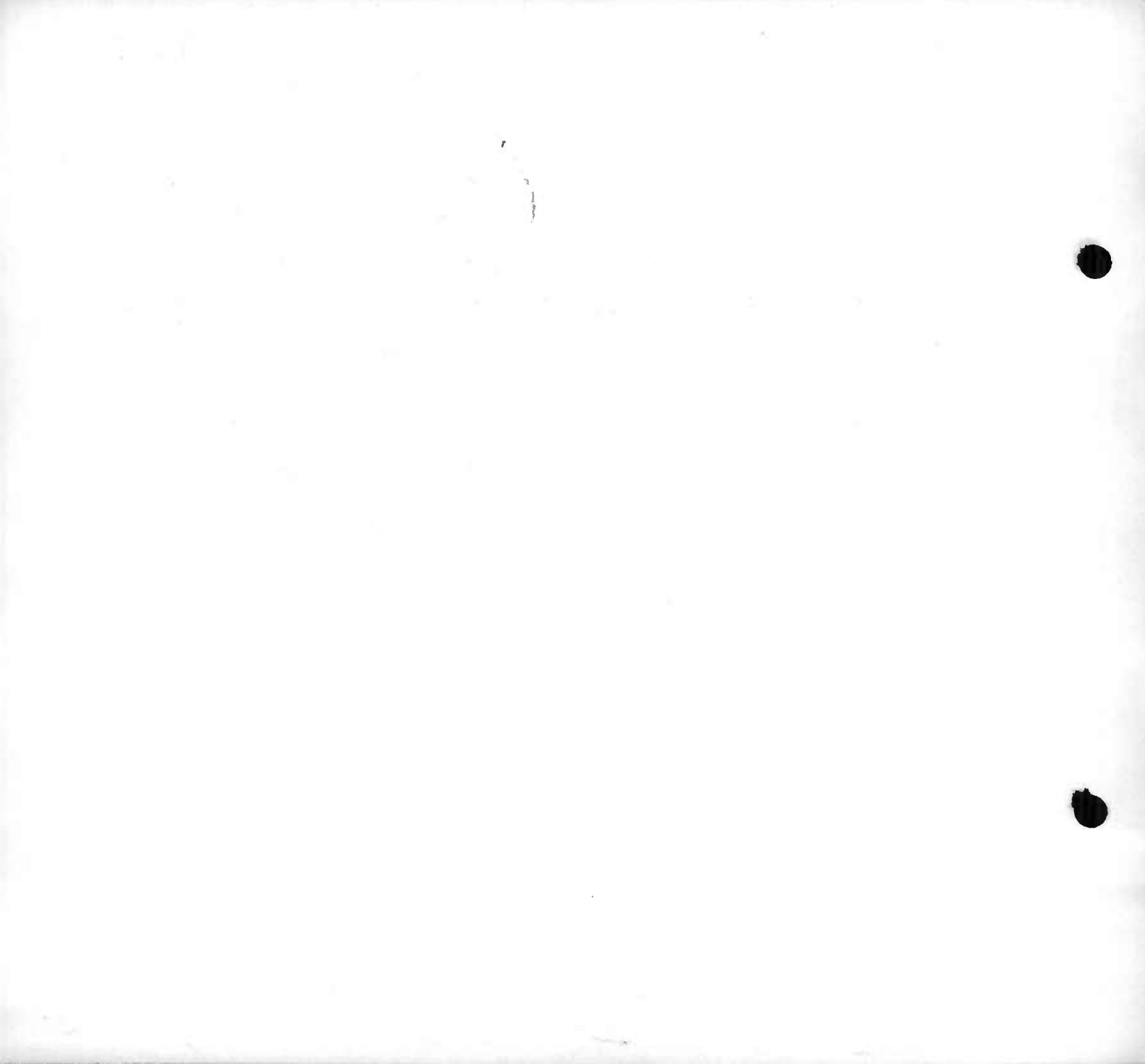
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3810</u>	
V-250 BIRTH NO. <u>71 3810</u>		71 3810 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Vaughn, Mrs Amazie D.</u>			2. DATE AND HOUR OF DEATH <u>4-16-71</u> <u>1:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md</u> B. COUNTY <u>2001</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u> <u>34</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>BLACK</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/4/04</u>		9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			13. FATHER'S NAME <u>950 DICKERSON</u>		
14. MOTHER'S MAIDEN NAME <u>SALLY JO LOOATN</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Vaughn Family 1837 Mulberry St</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Pulmonary Edema</u> <u>Poss. myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HASCD</u> <u>Hypertension</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>hrs.</u> <u>15 yrs.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>4-15</u> 19 <u>71</u> to <u>4-16</u> 19 <u>71</u> that (H) (we) lost saw the deceased alive on <u>4-16</u> 19 <u>71</u> and that (H) (my) (our) apin/an death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. DeBorja M.D.</u>				23B. DATE SIGNED <u>4-16-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lilia Lafranco - deBorja M.D.</u>				23D. ADDRESS <u>Bon Secours Hosp. Balto. Md. 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4/14/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenwood</u>	
24D. LOCATION (City, town, or county) (State) <u>San Antonio TX</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Manuel P. Hays</u>		25D. ADDRESS <u>1387 Green St</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3811</u>
BIRTH NO. <u>D-282</u>		71 3811		
1. NAME OF DECEASED (Type or Print) <u>DOUGLASS WILLIAM H.</u>		2. DATE AND HOUR OF DEATH <u>4.16.71 8.45 P M</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MD CON HOOR</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1303</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2524 MADISON AVE</u>		
5. SEX <u>M</u>	6. RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>100 1885</u>	9. AGE (In years last birthday) <u>86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Postal Employee - Asgmt</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WWI</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wm. Evans - Taunton Mass</u> ADDRESS		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Bladder approx. 6 months</u> with metastases to peritoneum, pleura lungs and bone.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4.16.71</u> 19 to <u>4.16.71</u> 19 that (I) (we) lost saw the deceased alive on <u>4.16.71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>J. Gerard Crowley</u>		23B. DATE SIGNED <u>4.16.71</u>		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4/20/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>MA CALVARY</u>
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Mr. R. Hays 635 N. G. Ave. St</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-622 71 3812				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3812	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FIMIRA G. BURGESS				2. DATE AND HOUR OF DEATH APRIL 16-1971 1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1603			
FULL NAME OF HOSPITAL OR INSTITUTION 00636 N. GILMORE ST				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 636 N GILMORE ST			
5. SEX 60	6. RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-10-1914	9. AGE (in years lost birthday) 56	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME JAMES POWELL				14. MOTHER'S MAIDEN NAME LAURA WHEATLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 214-26-5993		17. INFORMANT HELMA FOREST 1004 E. Pratt St		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROSIS				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CONGESTIVE HEART FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 16 19 71 to April 16 19 71 that (I) (we) last saw the deceased alive on 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE GILBERT L. BANFIELD				23B. DATE SIGNED 4/16/71		23C. PHYSICIAN'S NAME (Type) GILBERT L. BANFIELD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 4/20/71		24C. NAME OF CEMETERY OR CREMATORY MT ARBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Marshall P. Hays		ADDRESS 357 GILMORE ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3813	
BIRTH NO. D-620 71 3813		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDNA PARKS			2. DATE AND HOUR OF DEATH 4/18/71 10:40 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 1901		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING HOME 90 LAFAYETTE + JOHN STS.			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/1/94		9. AGE (in years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT KNOWN			11. BIRTHPLACE (State or foreign country) NOT KNOWN		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME NOT KNOWN			14. MOTHER'S MAIDEN NAME NOT KNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT CATHARINE BELL ADDRESS 211 Vincent St
18. 4/12/71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE cerebral infarction DUE TO, OR AS A CONSEQUENCE OF: Cerebral left (B) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/12/71 years years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/18 19 71 to 4/18 19 71 that (I) (we) last saw the deceased alive on 4/18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/19/71
23C. PHYSICIAN'S NAME (Type) JALAN H. MACHADO			23D. ADDRESS 211 Vincent St		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/71		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) BALTIMORE					
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR [Signature] ADDRESS 13511 Gilman	



1		21 3814		BALTIMORE CITY HEALTH DEPARTMENT		X	
S-531		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 3814	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
		JON SANDBECK		3. DATE PRONOUNCED DEAD		Month Day Year Hour April 16, 1971 8:40 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
40 ST. AGNES HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY Pr. Georges 6600	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male	White			Camp Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
April 7-1944		27		Washington, DC.		USA	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Robert C. Sandbeck		None		AnnaBelle Love			
17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Robert C. Sandbeck Same as # 5		Multiple Injuries			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Street		695 1/2 mi. S. of State Rt. 172			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
4-16-71 8:25 A. m.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Pedestrian struck by truck			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		4/16/71			
Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-2-1971		Cedar Hill Cemetery		Suitland, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 20 1971		Robert E. Fisher, M.D.		Simmons Bros		Wash DC	
				Simmons Bros. 1661-Good Hope Rd SE			

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

FUNERAL DIRECTOR: IMPORTANT

This certificate must be moved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3815</u>	
P-600 <u>71 3815</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Kimberly J. Poore</u>		2. DATE AND HOUR OF DEATH <u>4-15-71</u> <u>1 9</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>44</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md.</u> B. COUNTY <u>Talbot</u>	
		C. CITY OR TOWN <u>Bozman</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>Bcx 293</u>		<u>21812</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-63</u>	9. AGE (In years last birthday) <u>7</u>	10. AGE (In years last birthday) <u>7</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alan T. Poore</u>		14. MOTHER'S MAIDEN NAME <u>Rea Sweitzer</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Alan T. Poore, Bozman Md.</u>	
18. <u>1929 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio respiratory Arrest</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Medulla blastoma</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>—</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/4</u> 19 <u>71</u> to <u>4/15</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4/15</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William F. DeLoe MD</u>				23B. DATE SIGNED <u>4/15/71</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>Apr. 16, 1971</u>		<u>Bozman Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Harmon Funeral Home St. Michaels, Md.</u>	



71 3816

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3816

BIRTH NO.

1. NAME OF DECEASED **ROBERT HENRY JENNINGS**
(Type or Print) **ROBERT JENNINGS-**2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location)
005021 Pennington Ave. **4-27-71**
6-3-713. DATE PRONOUNCED DEAD Month Day Year Hour
4 14 1971 12:40 PM5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE **Md.** B. COUNTY **2505**

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2-19-21

10. AGE (In years lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

5021 Pennington Ave.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

A. MILTON JENNINGS

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

WATCHMAN

14B. KIND OF BUSINESS OR INDUSTRY

BOSTON METAL CO.

15. MOTHER'S MAIDEN NAME

ELLA B. METCALF

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

YES

W.W. II

17. SOCIAL SECURITY NO.

218-09-0002

18. INFORMANT

A. MILTON JENNINGS 6912 EASTBROOK AVE.

ADDRESS

19.

485 X 1/2 3032

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

Hypertensive & arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE **Bronchopneumonia, bilateral**
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Chronic alcoholism; hypertensive and arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/14/71

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-17-71

24C. NAME OF CEMETERY or CREMATORY

GLEN HAVEN CEM.

24D. LOCATION (City, town, or county) (State)

RITCHIE HIGHWAY ANNE ARUNDEL CO. MD

25A. DATE REC'D BY HEALTH DEPT.

APR 20 1971

25B. NAME OF REGISTRAR

John E. Taylor, M.D.

25C. FUNERAL DIRECTOR

CHARLES S. ZEILER BALTO. MD 21224

ADDRESS

901 S. CONKLIN ST.

Letter from M.E.'s office
Letter from M.E.'s office

4-27-71
6-3-71

M.H.
M.H.

BURIAL 4-11-71 CEM HAVEN CEM RICHMOND HIGHWAY

YES M.W. 25 510 WOODA WILSON 3500 W. 14TH ST
WILSON WILSON 3500 W. 14TH ST B. WILSON
B. WILSON 3500 W. 14TH ST
B. WILSON 3500 W. 14TH ST

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3817

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Whitmore				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 71 9:15 a. M.			
6. SEX male				7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8/4/10		10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator				14B. KIND OF BUSINESS OR INDUSTRY Gasoline station		15. MOTHER'S MAIDEN NAME Minnie Campbell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				17. SOCIAL SECURITY NO. 214 12 9165		18. INFORMANT 2806 Frederick Rd, Catherine Whitmore Catonsville, Md 21228	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/17/71							
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/22/71		24C. NAME OF CEMETERY or CREMATORY Linthicum Chapel Cem.		24D. LOCATION (City, town, or county) (State) Clarksville Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR John E. [unclear]		25C. FUNERAL DIRECTOR ADDRESS Higinbotham Slack Ellicott City, Md. 21043			

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

WALLACE P. DAVIS

WALLACE P. DAVIS

32

33

34

35

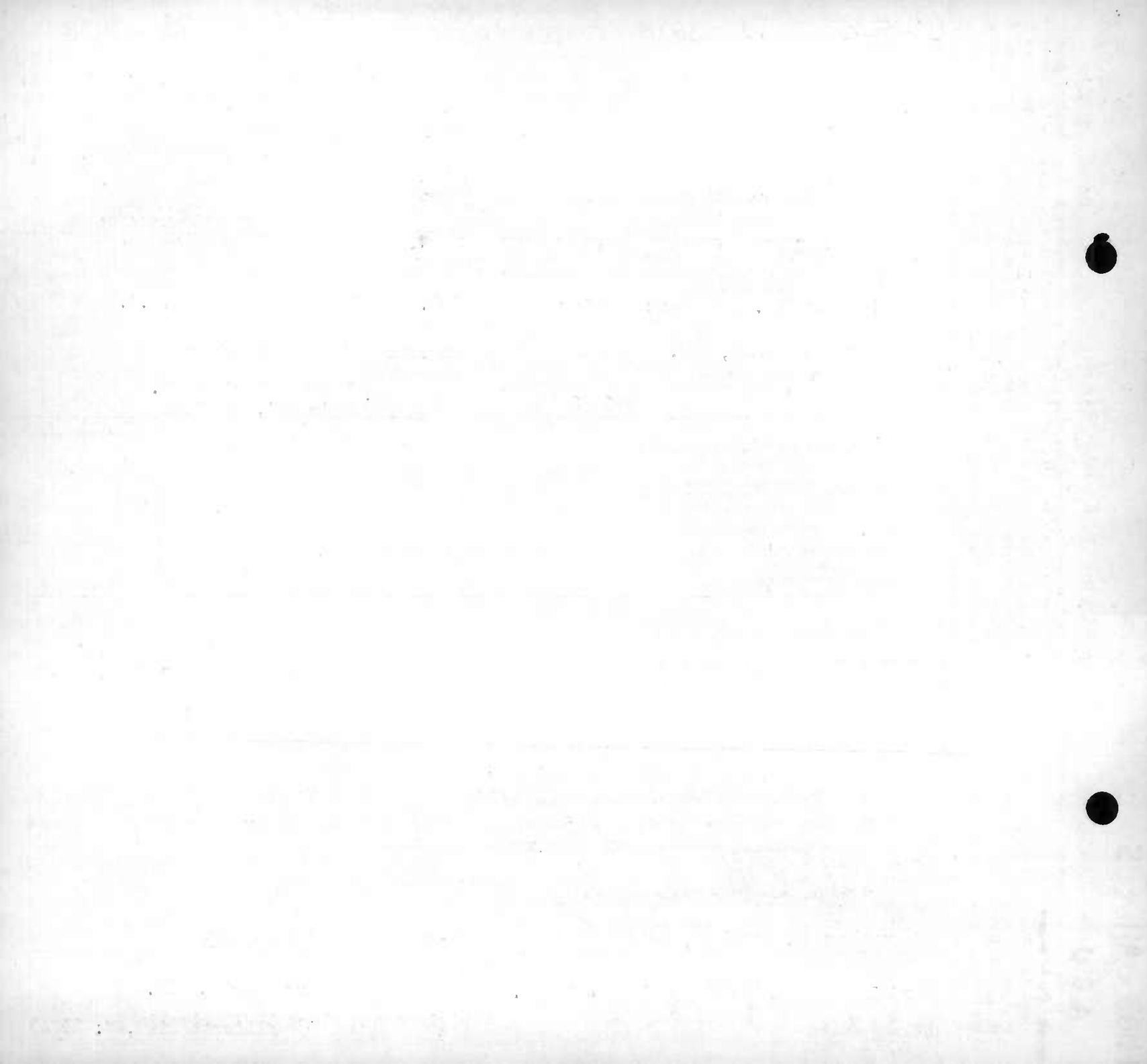
36

37

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
C-500 71 3818 CERTIFICATE OF DEATH X REG. NO. 71 3818											
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) CONN, Joseph H						2. DATE AND HOUR OF DEATH 4/15/71 1 50 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard					
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital						C. CITY OR TOWN Glenwood D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						E. STREET AND NUMBER 14022 Celbridge Drive 21738					
5. SEX Male		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/02/38		9. AGE (In years last birthday) 33		10. IF UNDER 1 Yr. Months Days IF UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Goddard Space Cen.				10B. KIND OF BUSINESS OR INDUSTRY Space Center				11. BIRTHPLACE (State or foreign country) Mich.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Joseph Conn, Sr.				14. MOTHER'S MAIDEN NAME Augusta McFarlane			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 263 52 1448				17. INFORMANT ADDRESS Sondra Conn 14022 Celbridge Dr. Glenwood, Maryland 21738			
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Reticulum Cell Sarcoma 2 months											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 4/12/71				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Personal opinion				20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/11 1971 to 4/15 1971 , that (I) (we) last saw the deceased alive on 4/15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.											
23A. SIGNATURE Douglas L. Hurley, MD								23B. DATE SIGNED 4/15/71		23C. PHYSICIAN'S NAME (Type) Douglas L. Hurley, MD	
23D. ADDRESS Johns Hopkins Hospital								23E. ADDRESS Johns Hopkins Hospital		23F. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/21/71				24C. NAME OF CEMETERY or CREMATORY Hillcrest Cem.			
24D. LOCATION Vero Beach, Fla.				24E. LOCATION Vero Beach, Fla.				24F. LOCATION Vero Beach, Fla.			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971				25B. NAME OF REGISTRAR Johns Hopkins Hospital				25C. FUNERAL DIRECTOR Higinbotham Slack 3871 Columbia Rd. Hillcrest City, Md. 21043			

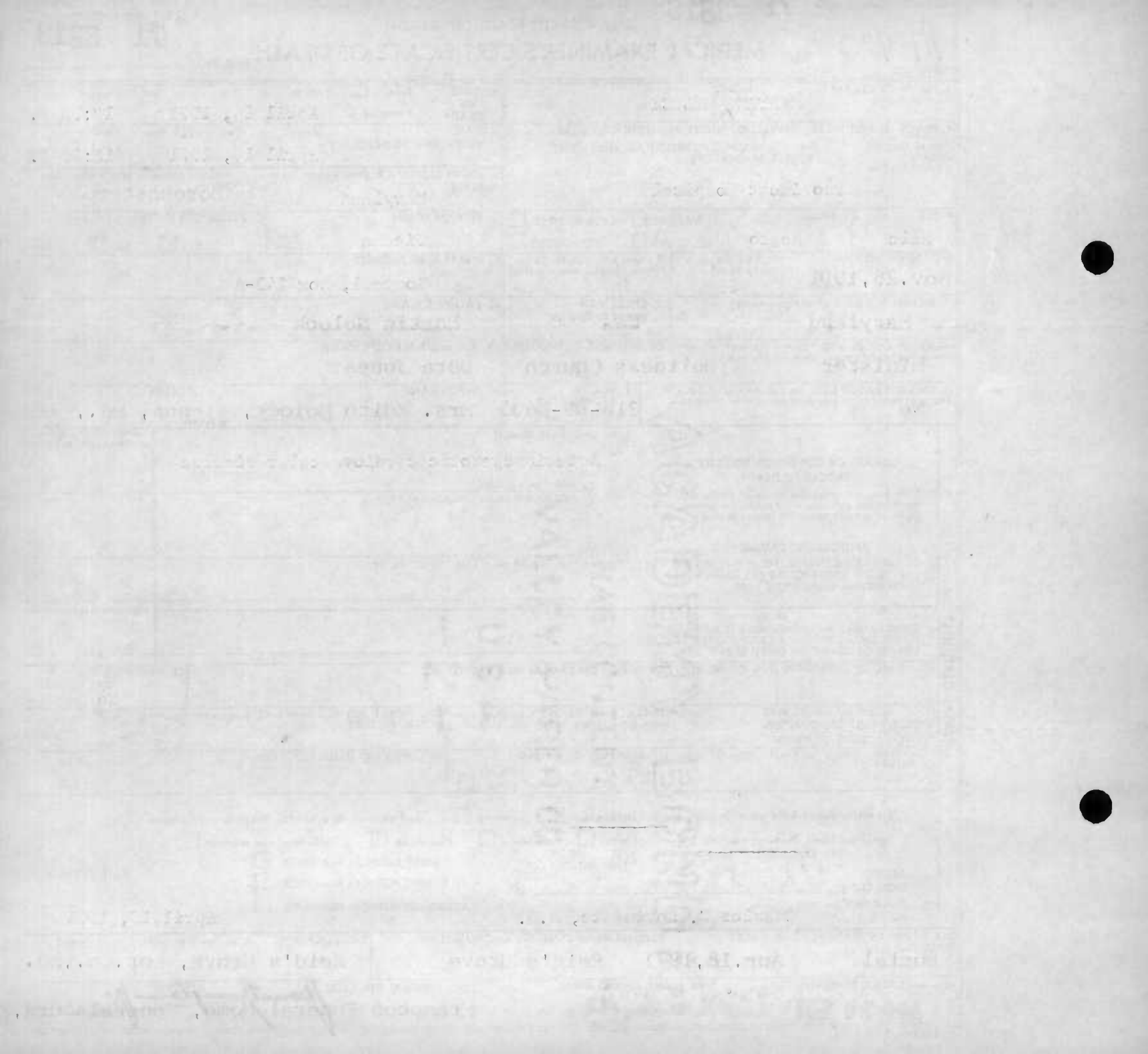


BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LEE MARTIN MOLOCK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 14, 1971 12:35 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 14, 1971 12:35 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Dorchester 5900		6. SEX Male 7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Vienna D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Nov. 26, 1901 10. AGE (In years last birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER Route 1, Box 243-A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF USA	
13. FATHER'S NAME Martin Molock		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	
14B. KIND OF BUSINESS OR INDUSTRY Holiness Church		15. MOTHER'S MAIDEN NAME Dora Jones	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-09-0635	
18. INFORMANT Mrs. Edith Molock, Vienna, Md., RFD		ADDRESS	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 15, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 18, 1971	
24C. NAME OF CEMETERY or CREMATORY Reid's Grove		24D. LOCATION (City, town, or county) (State) Reid's Grove, Dor. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR James S. Springate, M.D.	
25C. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Md.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3820
CERTIFICATE OF DEATH				REG. NO.
BIRTH NO. <u>4-400</u>		71 3820		
1. NAME OF DECEASED (Type or Print) <u>Mary R. Hall</u>		2. DATE AND HOUR OF DEATH <u>April 16, 1971</u> <u>7:00 p.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Gould Convalesarium</u> <u>6116 Belair Road</u> <u>Baltimore, Maryland 21206</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2710</u>		
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>5314 Kenilworth Avenue</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1882</u>	9. AGE (in years last birthday) <u>88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Cornelius DeMoss</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Davis</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---No---		16. SOCIAL SECURITY NO. <u>215-56-3306-J</u>		17. INFORMANT <u>1 Charlotte Moore (Daughter)</u>
				ADDRESS <u>Same</u>
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<u>10 yrs.</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cardiovascular disease</u>				
(B) <u>Chronic brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>1 yr.</u>
(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1966</u> to <u>April 16, 1971</u> that (I) (we) last saw the deceased alive on <u>April 1, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Lloyd E. Saylor, M.D.</u>		23B. DATE SIGNED <u>Apr. 19, 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Lloyd E. Saylor</u>		23D. ADDRESS <u>3902 Greenmount Avenue Balto. 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/19/1971</u>	24C. NAME OF CEMETERY or CREMATORY <u>Green Mount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE RECEIVED BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>Charles E. Saylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Eugenia R. Seitz</u> ADDRESS <u>5209 York Road</u> <u>Seitz Funeral Home Balto. Md. 21212</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

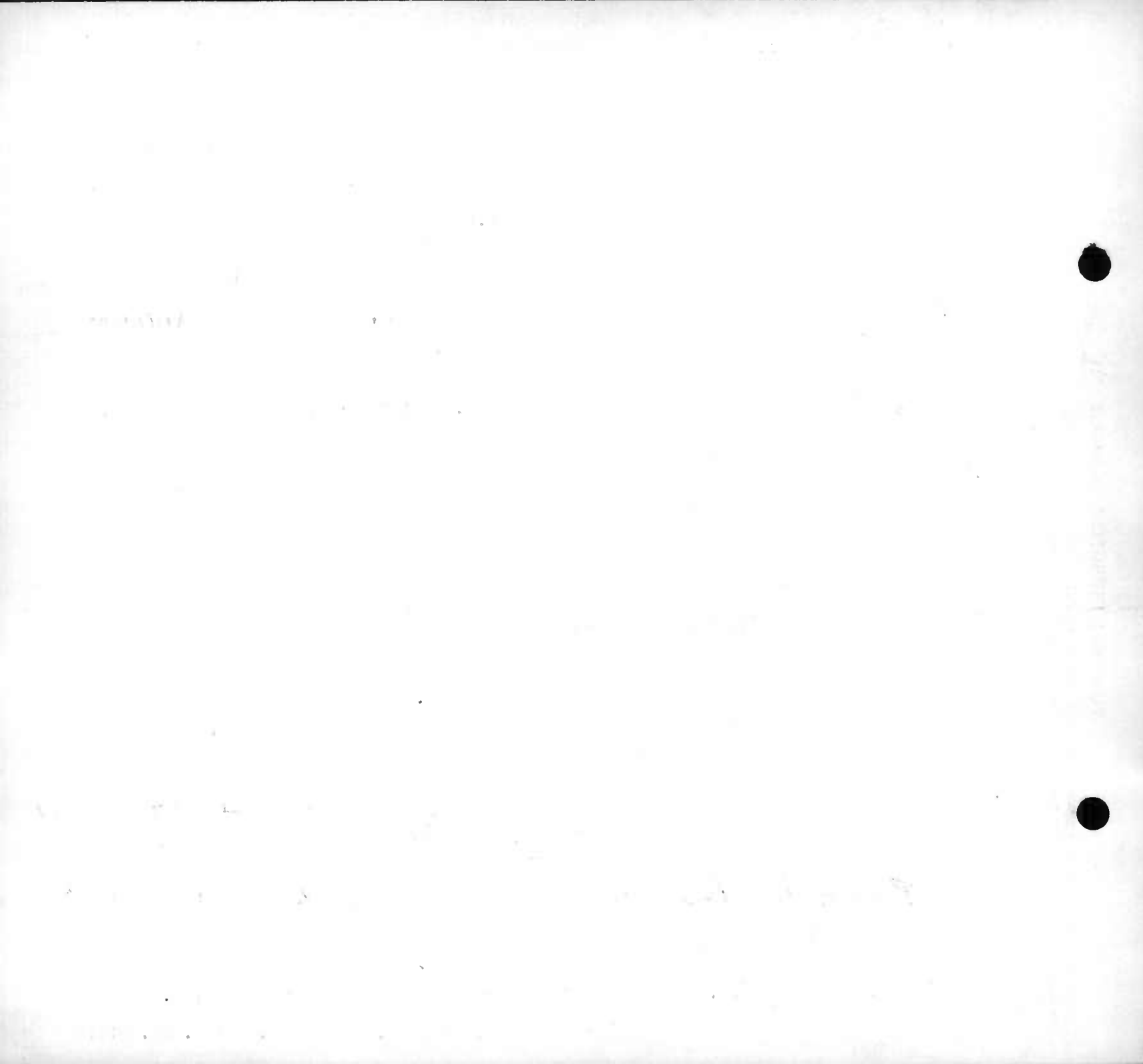
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3821	
1. NAME OF DECEASED (Type or Print) HERMAN JAMES CORKRAN		2. DATE AND HOUR OF DEATH 4-17-71 4:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 7323 HARFORD ROAD BALTIMORE, MD. 21234		A. STATE MD.		B. COUNTY 2735	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 7323 Harford Rd			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12, 1911	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY PETROLEUM		9. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JAMES Shell GORKRAN		14. MOTHER'S MAIDEN NAME NELLIE G. SELLERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NATIONAL GUARD 217-07-9324		16. SOCIAL SECURITY NO. 217-07-9324		17. INFORMANT WIFE 7323 Harford Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHogenic CARCINOMA LEFT WITH WIDESPREAD METASTASIS (PROVEN BY BIOPSY)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MOS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (B) _____ (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 4 1971 to APRIL 17 1971 that (I) (we) last saw the deceased alive on APRIL 15 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BENJAMIN V. DEL CARMEN, M.D.				23B. DATE SIGNED 4-17-71	
23C. PHYSICIAN'S NAME (Type) BENJAMIN V. DEL CARMEN, MD		23D. ADDRESS 6217 Harford Rd, Baltimore 21234			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/71		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 20 1971			
25B. NAME OF REGISTRAR John E. Taylor, MD		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

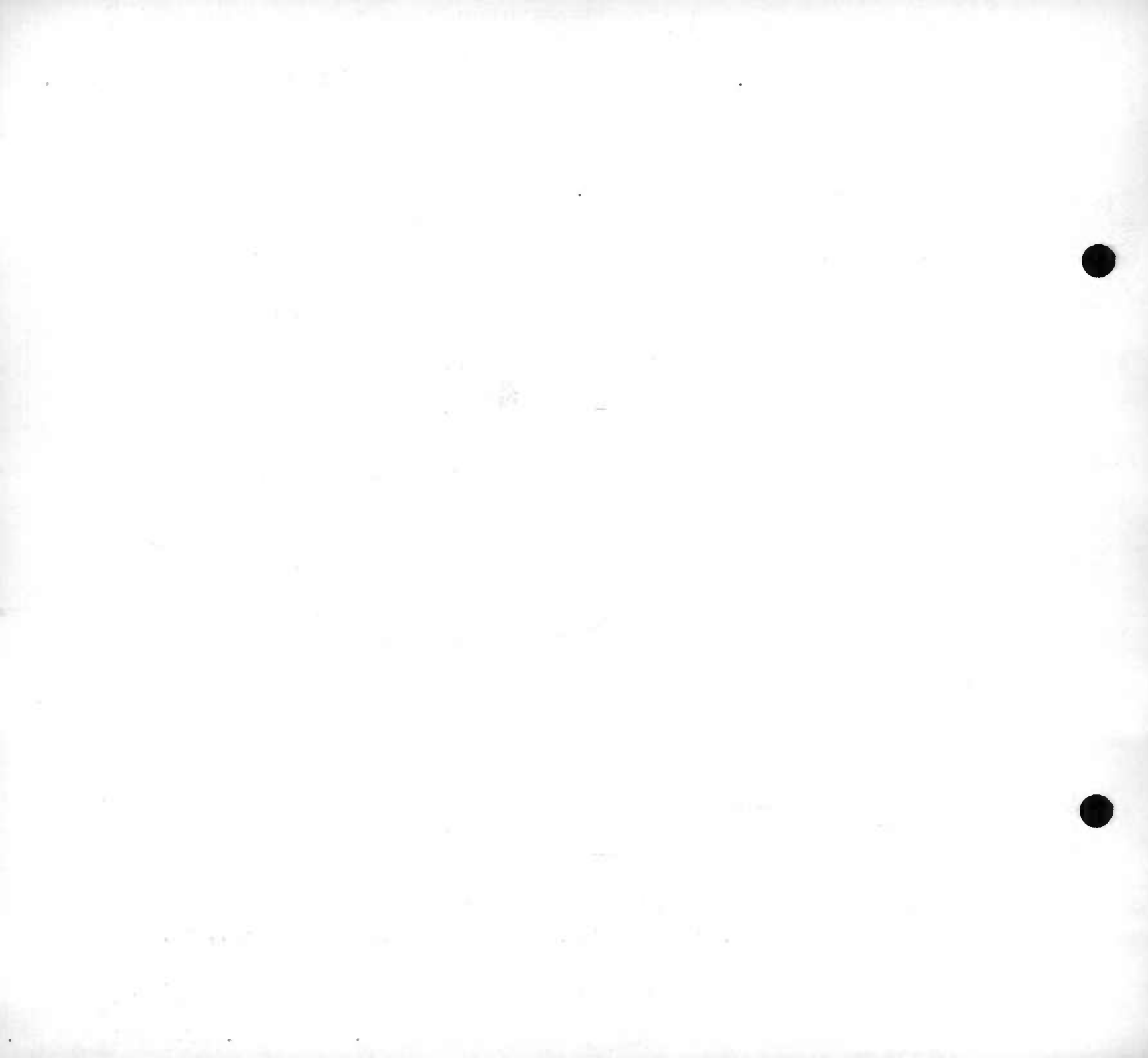
BALTIMORE CITY HEALTH DEPARTMENT				X	
71 3822				REG. NO. 71 3822	
1. NAME OF DECEASED (Type or Print) YACHIMOWICZ; MRS SOPHIE		2. DATE AND HOUR OF DEATH APRIL 17, 1971. 12:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND	
B. COUNTY Anne Arundel		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 13 PASADENA MD 21122					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04 11 92	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? AMERICA					
13. FATHER'S NAME CHARLES ZLOTORSKI		14. MOTHER'S MAIDEN NAME VICTORIA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 911 18 9049		17. INFORMANT Mrs. Marjorie Uebersax	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GENERALISED TOXEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GIANGRENE FOOT WITH CELLULITIS 1 MONTH		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DIABETES MELLITUS		17 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/10/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GIANGRENE RT LEG		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-26 19 71 to 4-17 19 71 that (I) (we) last saw the deceased alive on 4-17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Prabir K. Bose M.D.				23B. DATE SIGNED 4-17-71	
23C. PHYSICIAN'S NAME (Type) PRABIR. K. BOSE M.D.		23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/71		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cemetery	
24D. LOCATION Baltimore, Md.					
25A. DATE RECEIVED BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3823
BIRTH NO. R-256 71 3823		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Edward E. Rossmark		2. DATE AND HOUR OF DEATH 4/18/71 1:10 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in Pines- Belair Rd.		A. STATE Maryland B. COUNTY Balto.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Rosedale		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6/15/1898		9. AGE (In years last birthday) 72		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Arthur Rossmark		
14. MOTHER'S MAIDEN NAME Grace Crow		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-05-5093		17. INFORMANT Mrs. LaVerne Novak		
18. ADDRESS Same		19. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 43291		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Cerebrovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) Cerebrovascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF:		months
(C) Arteriosclerotic Heart Disease Phlebotomy by Chronic Pain Syndrome				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/3/71 to 4/18/71 that (I) (we) last saw the deceased alive on 4/17/71 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.				
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 4/18/71		23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D.
23D. ADDRESS 4900 Belair Road Balto., Md. 21206		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4/21/71		24C. NAME OF CEMETERY OR CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		2 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2735</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3125 Woodhome Ave.</u>			
5. SEX <u>F.</u> 6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/1886</u> 9. AGE (in years last birthday) <u>85</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.N.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sinai Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip G. Bramble</u>			14. MOTHER'S MAIDEN NAME <u>Minnie</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW 1</u>		16. SOCIAL SECURITY NO. <u>212-36-6838</u>		17. INFORMANT <u>Mrs. Carol R. Dome</u> ADDRESS <u>7412 Park Dr.</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION loss.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u> <u>6 years</u>	
(A) IMMEDIATE CAUSE <u>Terminal Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>2 days</u>	
(B) <u>H A S H I D</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>10 years</u>	
(C) <u>C V A (Residual)</u>				<u>6 years</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> 19 <u>46</u> to <u>4/18/71</u> 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>4/17</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Israel S. Zinberg MD.</u>				23B. DATE SIGNED <u>4/19/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Israel S. Zinberg MD.</u>				23D. ADDRESS <u>4000 Northern Parkway Balto. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>4/19/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>	
25D. ADDRESS					

THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

110 N. 5TH ST. NEW YORK, N.Y.

1911

1911

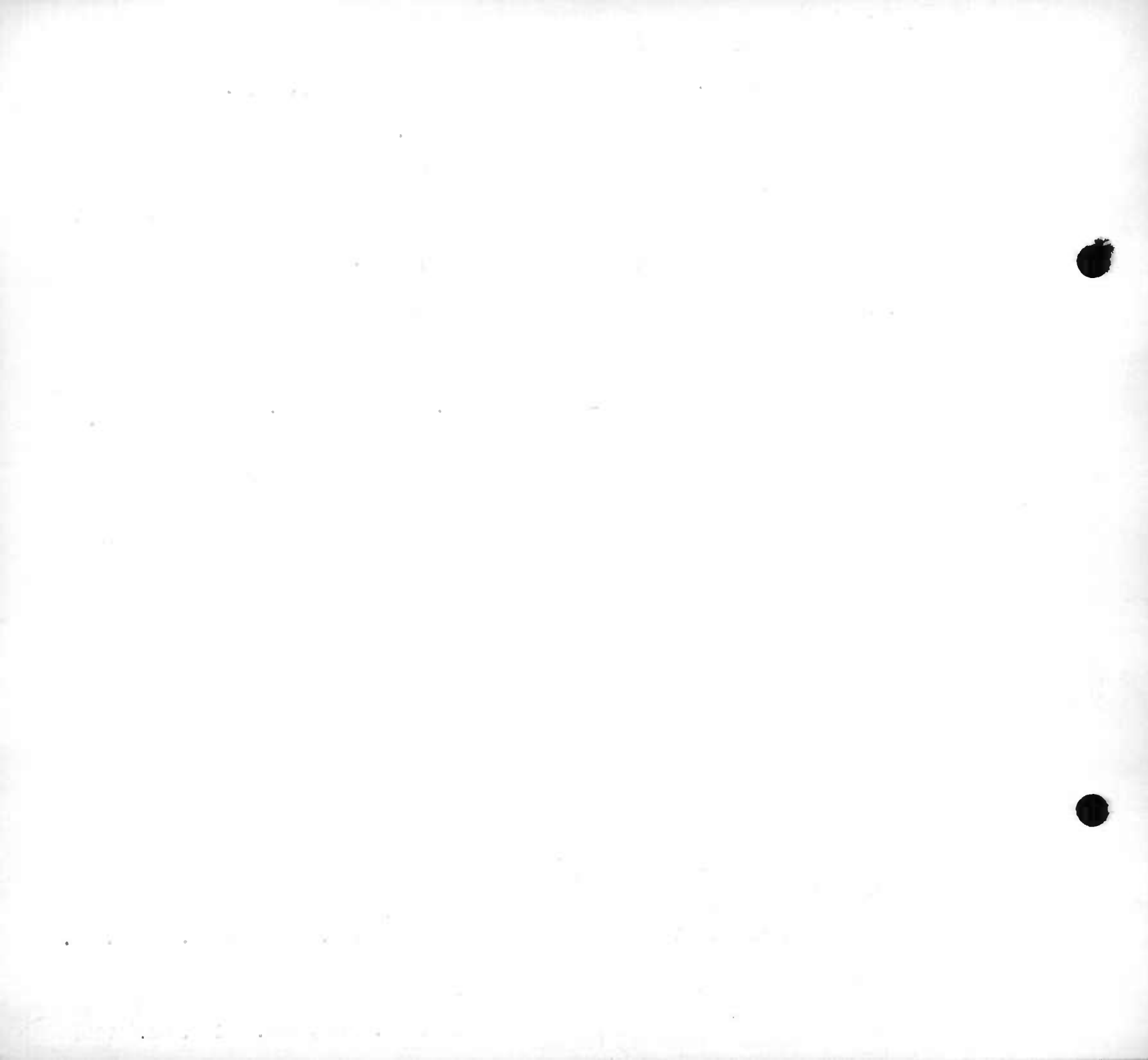
1911

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

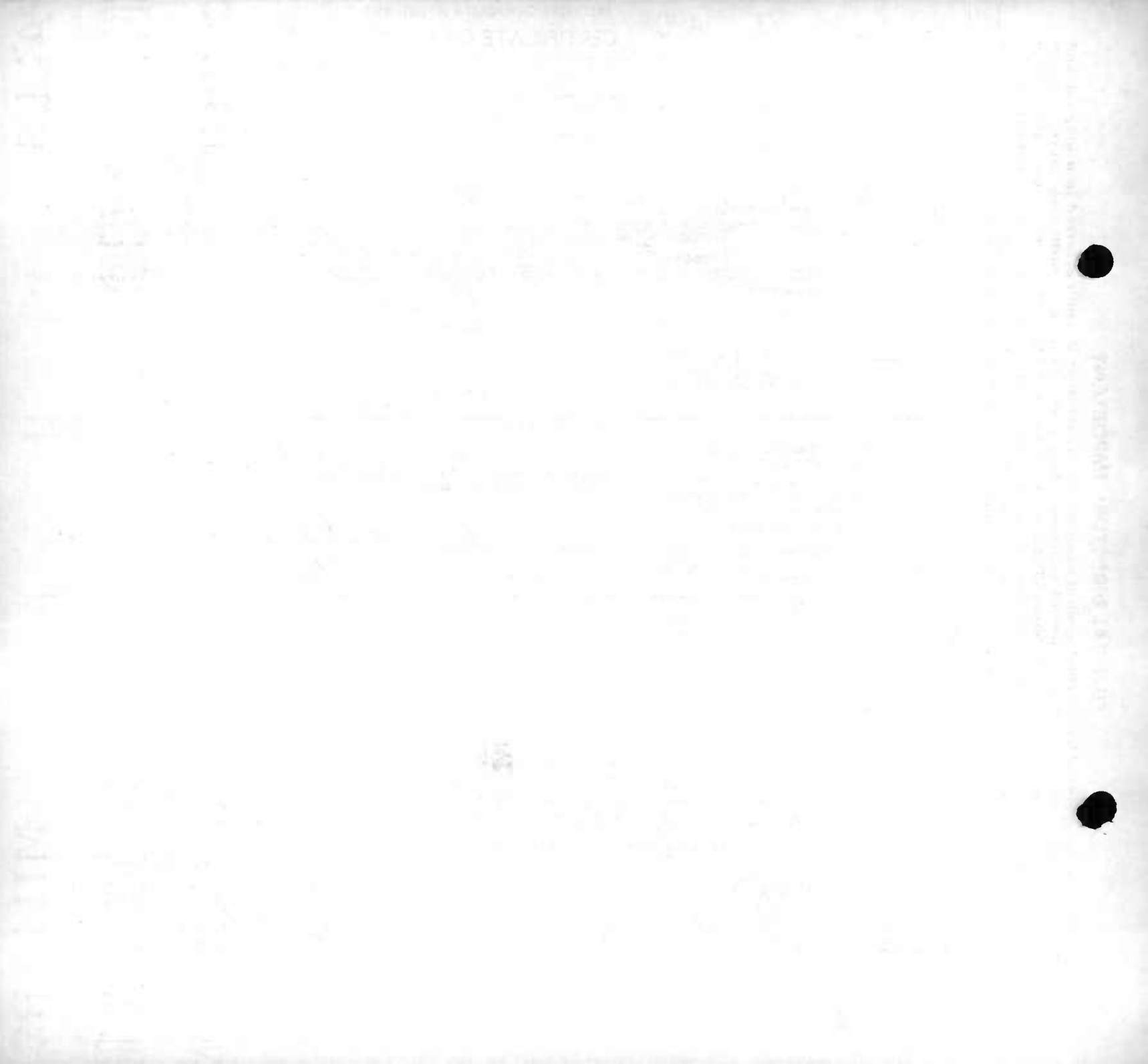
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3825</u>
7-655 BIRTH NO. <u>71 3825</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) RUTH N. FOREMAN		2. DATE AND HOUR OF DEATH April 17, 1971.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 921 North Kresson Street		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2664		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 921 North Kresson Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1897.	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles William Brooks		
14. MOTHER'S MAIDEN NAME Charlotte Gambell		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-09-5088		17. INFORMANT Mrs. Marguerite B. Ferguson		
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 1
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/5/71 19 to 4/17/71 19 that (I) (we) last saw the deceased alive on 4/12/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Louis Vogel M.D.		23B. DATE SIGNED 4/19/71		
23C. PHYSICIAN'S NAME (Type) Louis Vogel MD		23D. ADDRESS 2601 E. Monument St. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/71		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial
24D. LOCATION Baltimore Maryland				
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Alfred E. ...		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-552 71 3826				BALTIMORE CITY HEALTH DEPT		CERTIFICATE OF DEATH		REG. NO. 71 3826	
BIRTH NO. <u>MARY SEMENIUK</u>				1. NAME OF DECEASED (Type or Print) <u>MARY Semeniak</u>		2. DATE AND HOUR OF DEATH <u>4/16/71</u> <u>7:125</u> <u>P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Balt. Gen.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>1615</u> <u>South St.</u> <u>Maryland</u> B. COUNTY <u>2506</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/27/196</u>		9. AGE (in years last birthday) <u>74</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>Semeniak</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-01-4419</u>		17. INFORMANT <u>Frederick Semeniak</u>		ADDRESS	
18. <u>4/10/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) <u>Arterio Sclerotic Cardiovascular Disease</u> (C) <u>Pulmonary Edema</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (1) (this hospital) attended the deceased from <u>4/11</u> 19 <u>71</u> to <u>4/16</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Thirlop</u>				DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/16/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONALD HISCOP</u>				DEGREE		23D. ADDRESS <u>South Balt. Gen.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-20-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) <u>Baltimore</u>		STATE <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Kelley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Hahn Funeral Home</u> ADDRESS <u>4200 Pennington Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

71 3827

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILSON, Clarence

2. DATE AND HOUR OF DEATH

4/17/71

10:06 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

3908 Southern Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5/28/93

9. AGE (in years
last birthday) 77If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiopulmonary arrest
ASCVD, Semblity
CAD

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

minutes

? 204.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).Adenocarcinoma of Parotid
gland

73 years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 4/17 19 71 to 4/17 19 71
that (1) (we) last saw the deceased alive on never 19 and that (1) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Bernadine H. Bullock

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/19/71

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

4/19/71

24C. NAME OF CEMETERY OR CREMATORY

Johns Hopkins Univ. - Anatomy Baltimore, MD

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 20 1971

Robert E. Taylor, M.D.

J.H.U. DEPT. OF ANATOMY



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3828	
BIRTH NO. 71 3828		71 3828			
1. NAME OF DECEASED (Type or Print) ANDREW ADAMS		2. DATE AND HOUR OF DEATH 4/18/71 5 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 201			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 14940 EASTERN AVENUE, BALTO MD.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		8. DATE OF BIRTH 3-10-08	
13. FATHER'S NAME Charlie ADAMS		14. MOTHER'S MAIDEN NAME Anzie MITCHELL		9. AGE (In years last birthday) 63	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 256-015713		11. BIRTHPLACE (State or foreign country) Georgia	
17. INFORMANT BCH Records: Baltimore, Md. 21224		12. CITIZEN OF WHAT COUNTRY? U.S.A.		1927 E. Baltimore St. 21231 007	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) carcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). pericardial metastasis -> PVCs		1 month			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/18 to 4/18 19 71 and that (2) (we) lost saw the deceased alive on 4/18 19 71 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.		23A. SIGNATURE Joseph Roll M.D.		23B. DATE SIGNED 4-18-71	
23C. PHYSICIAN'S NAME (Type) Joseph Roll M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE APR 21 1971		24C. NAME OF CEMETERY OR CREMATORY CREST LAWN GARDENS		24D. LOCATION (City, town, or county) (State) AT# 40 BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST	

THE BOARD OF DIRECTORS

OF THE COMPANY

RESOLVED

THAT

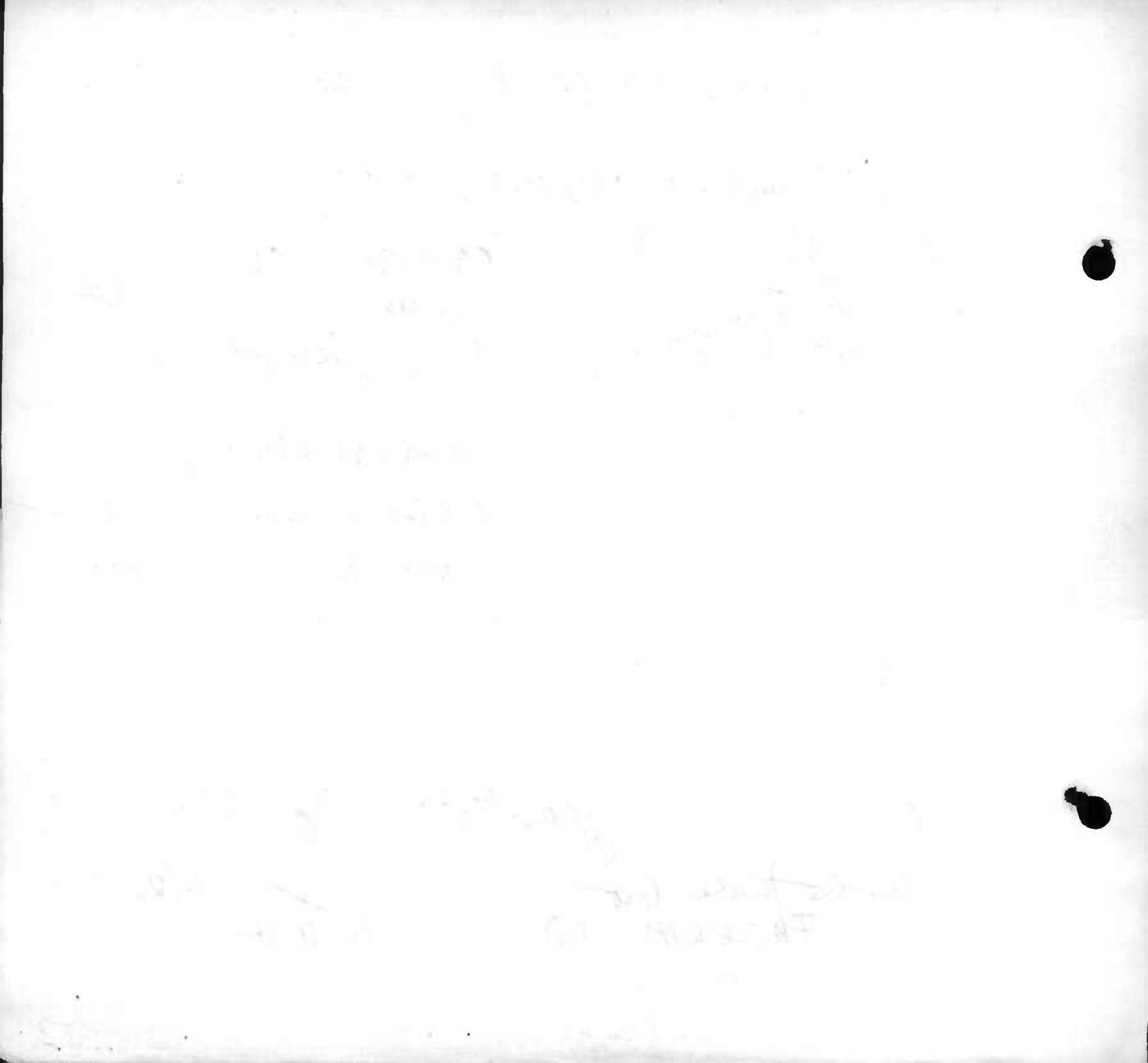
BE IT RESOLVED

THAT THE BOARD OF DIRECTORS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

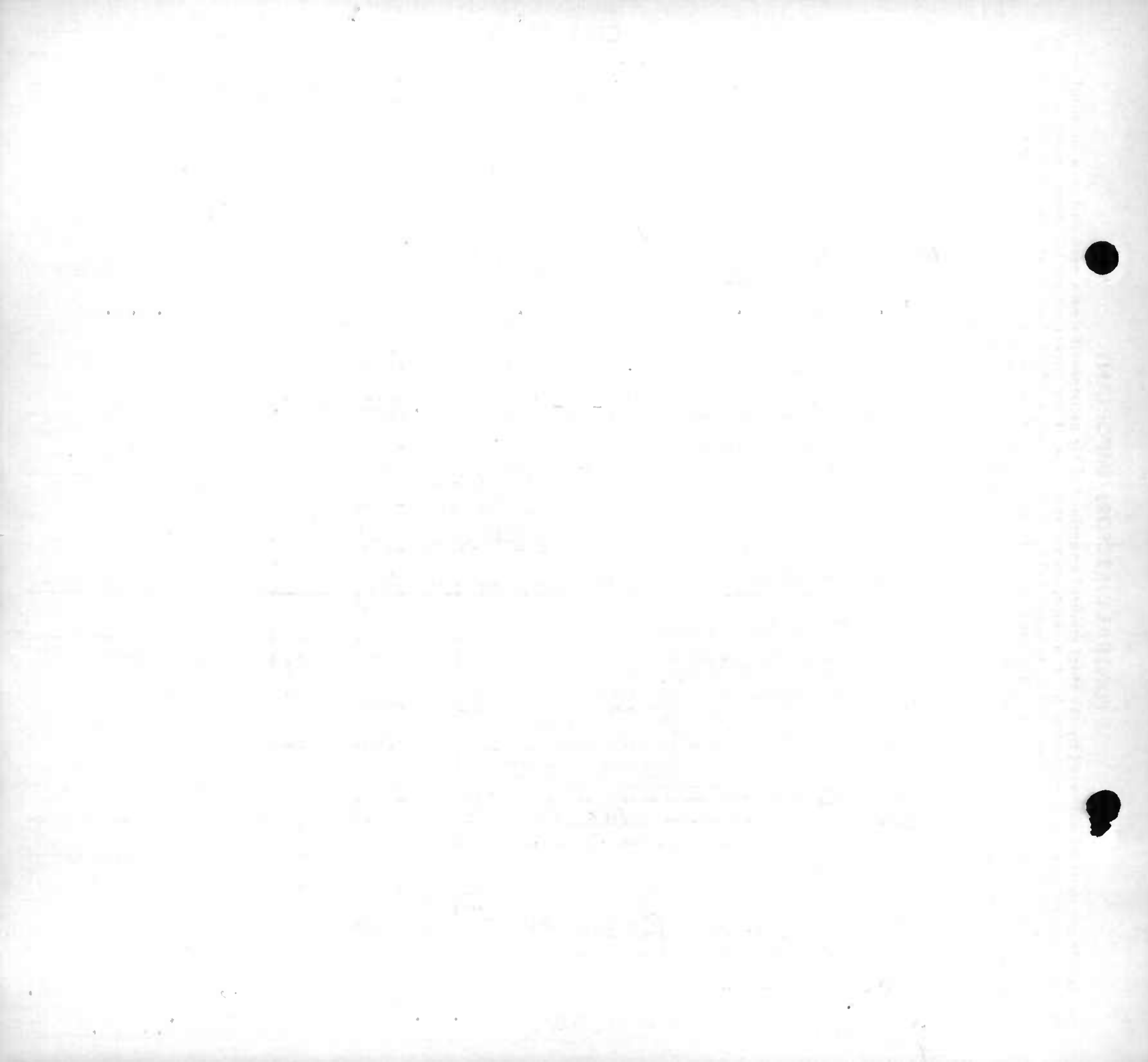
BIRTH NO. 71 3829		CITY HEALTH DEPT. CERTIFICATE OF DEATH		REG. NO. 71 3829	
1. NAME OF DECEASED (Type or Print) <u>Sibley George N.</u>		2. DATE AND HOUR OF DEATH <u>4/20/71</u> <u>5 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>Md</u>		B. COUNTY <u>2759</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4224 Kelway Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09-11-90</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE MANAGER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AMERICAN SUGAR REF. CO.</u>		9. AGE (in years last birthday) <u>80</u>	
13. FATHER'S NAME <u>George L Sibley</u>		14. MOTHER'S MAIDEN NAME <u>Boyle Josephine</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>011-10-3165A</u>		17. INFORMANT <u>MRS. GEORGE N. SIBLEY (SAME)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>cerebral bleeding</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>High blood pressure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>None</u>		<u>yrs.</u>	
(C) <u>Prostatic hypertrophy</u>				<u>yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4/20/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <u>?</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>7/20</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> 19 <u>71</u> to <u>4/20</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles F. Jenkins</u>		23B. DATE SIGNED <u>4/20/71</u>		23C. PHYSICIAN'S NAME (Type) <u>FAZEKAS MD.</u>	
23D. ADDRESS <u>U. M. C.</u>		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>4/20/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Baltimore</u>		24E. LOCATION <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>	
				ADDRESS <u>4905 York Rd. Balto., Md. 21221</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

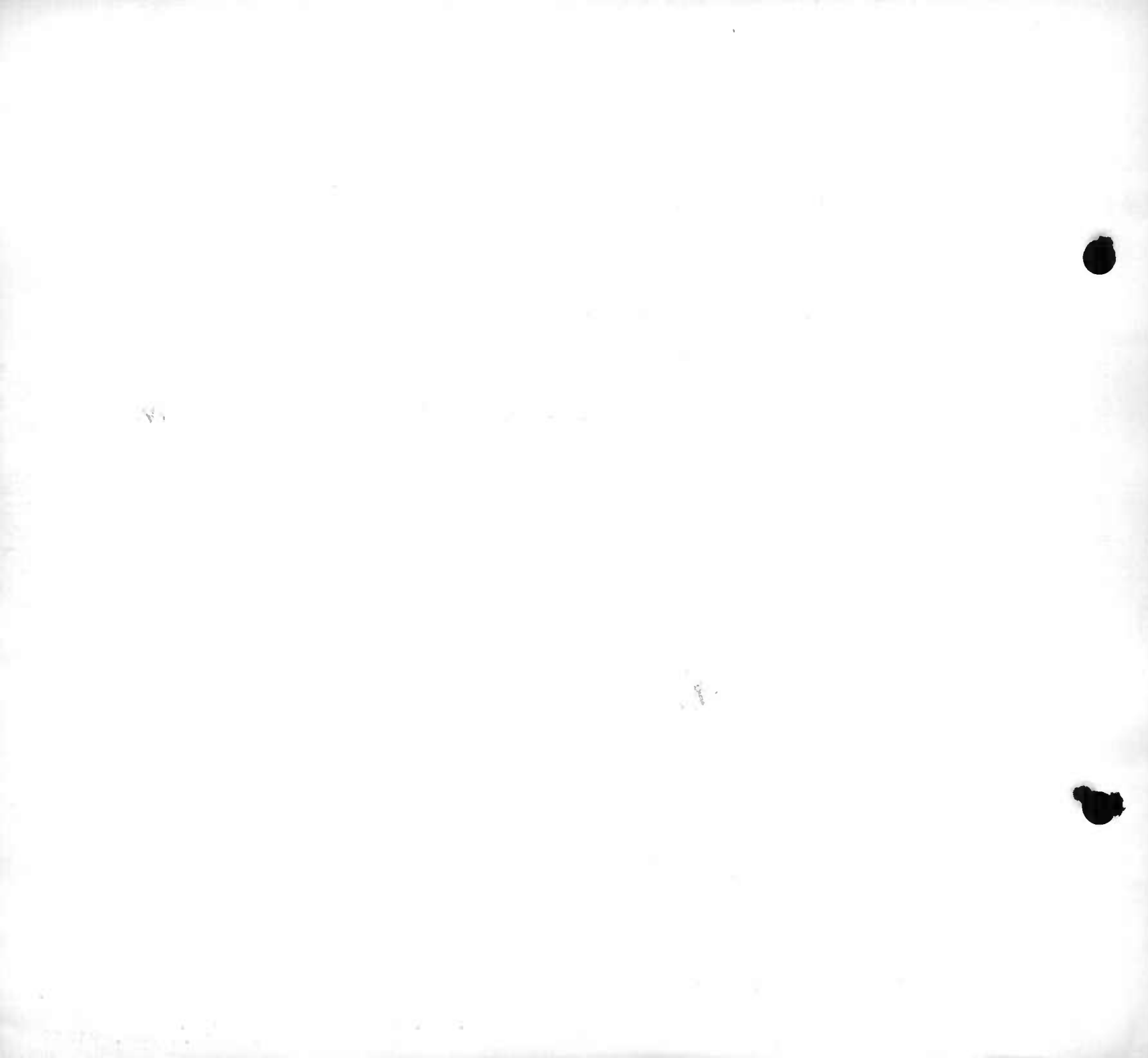
BALTIMORE CITY HEALTH DEPARTMENT						CERTIFICATE OF DEATH		REG. NO. <u>71 3830</u>	
BIRTH NO. <u>71 3830</u>		1. NAME OF DECEASED (Type or Print) <u>NORMAN C. Settle</u>				2. DATE AND HOUR OF DEATH <u>4/19/71 - 8:00 AM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2712</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <u>5206 Purlington Way</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02-14-92</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd. Vice Pres.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>McCormick & Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Isaac Settle</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bell Herzog</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-01-8874</u>		17. INFORMANT <u>A Mrs. Lillian D. Settle</u>				ADDRESS <u>Same</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pos. MI vs. poken suboles</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Severe ASCVD - severe renal failure</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>pos. sups 2° to pos. Gm ⊕ pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:					
				(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2-4-15-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ⓡ LE arterial occlusion</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>APR 12</u> 19 <u>71</u> to <u>APR 19</u> 19 <u>71</u> that <u>(1) (we)</u> last saw the deceased alive on <u>APR 19</u> 19 <u>71</u> and that in <u>(my)</u> your opinion death occurred on the date and hour and from the causes stated above. <u>(1) (we)</u> (did) (did not) view the body after death.									
23A. SIGNATURE <u>Steven Rubin MD</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-19-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>STEVEN RUBIN MD</u> DEGREE				23D. ADDRESS <u>JOHNS HOPKINS ASP BALTO MD</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-22-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley MD.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

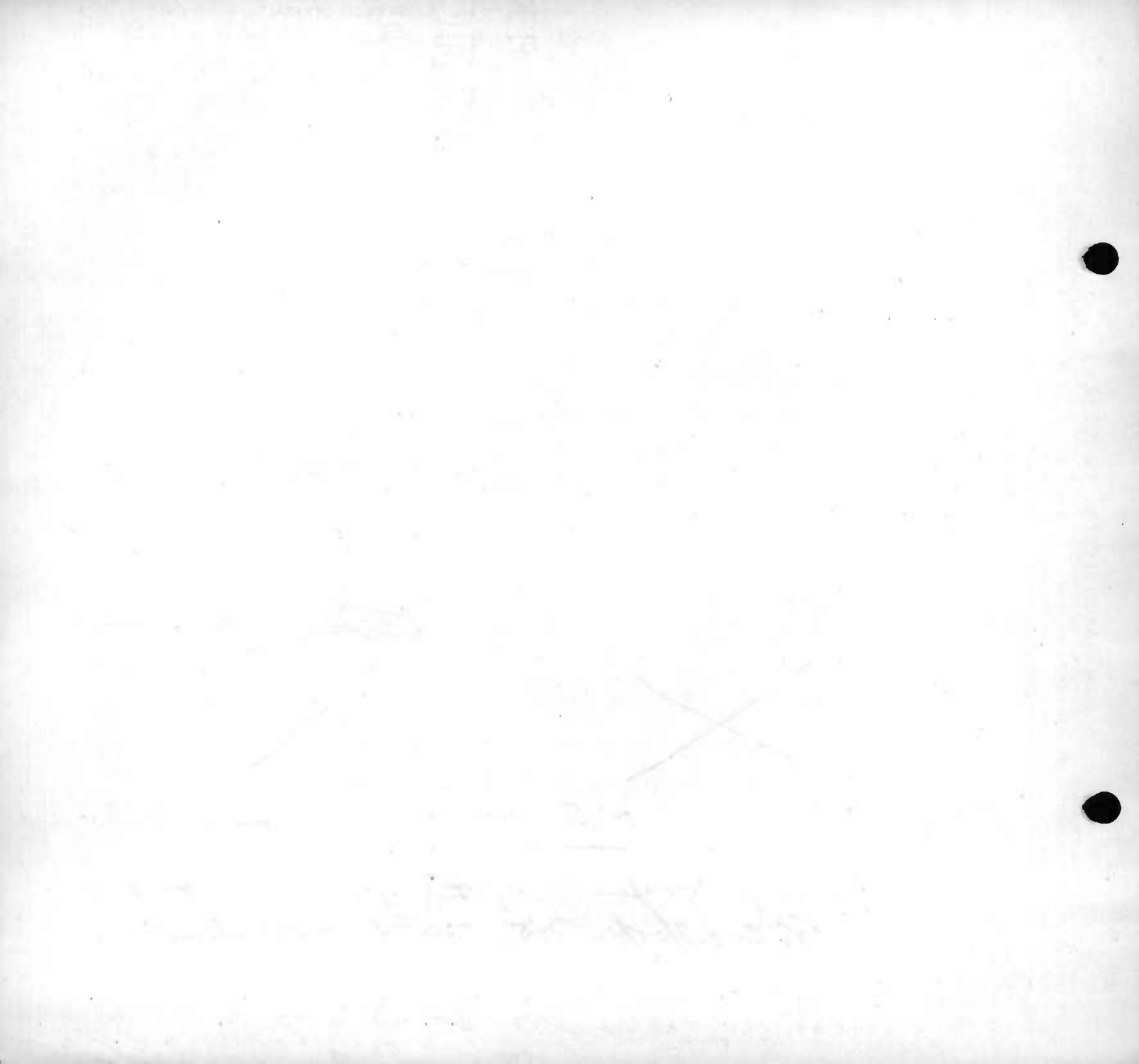
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3831	
BIRTH NO. 71 3831		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Harris, Mildred E.</i>			2. DATE AND HOUR OF DEATH <i>4/18/71 5 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>2748</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1105 E Belvedere Balto Md 21212</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>07-25-99</i>	9. AGE (In years last birthday) <i>71</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Brown, Walter L.</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth A. Brown</i>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-16-7615A</i>		17. INFORMANT <i>Robert J. Harris, 110 Boston Post Rd. RYE, N.Y.</i>	
18. <i>4-30-71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>subarachnoid hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased, from <i>4/16/71</i> to <i>4/18/71</i> that (I) (we) last saw the deceased alive on <i>4/18/71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Issam E. Cheikh</i>				23B. DATE SIGNED <i>4/18/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>ISSAM E. CHEIKH</i>				23D. ADDRESS <i>Union Memorial Hospital.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-21-1971</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 20 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3832	
BIRTH NO. 71 3832		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Edna B. Posey			2. DATE AND HOUR OF DEATH 4-17-71 3:07 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 903		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3520 Ellerslie Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3520 Ellerslie Ave.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1897		9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10B. KIND OF BUSINESS OR INDUSTRY Office	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward S. Posey, Sr.			14. MOTHER'S MAIDEN NAME Hilda Herman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-8611	17. INFORMANT Miss E. Anna Posey		ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4-12-71 CVD. Virus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) Virus DUE TO, OR AS A CONSEQUENCE OF:		
			(C) non		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CVD. non					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on April 4-17 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Z Vance Horner			23B. DATE SIGNED 4-17-71		
23C. PHYSICIAN'S NAME (Type) Z Vance Horner MD			23D. ADDRESS 3534 Ellerslie Ave		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore,		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR R. E. Taylor MD		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

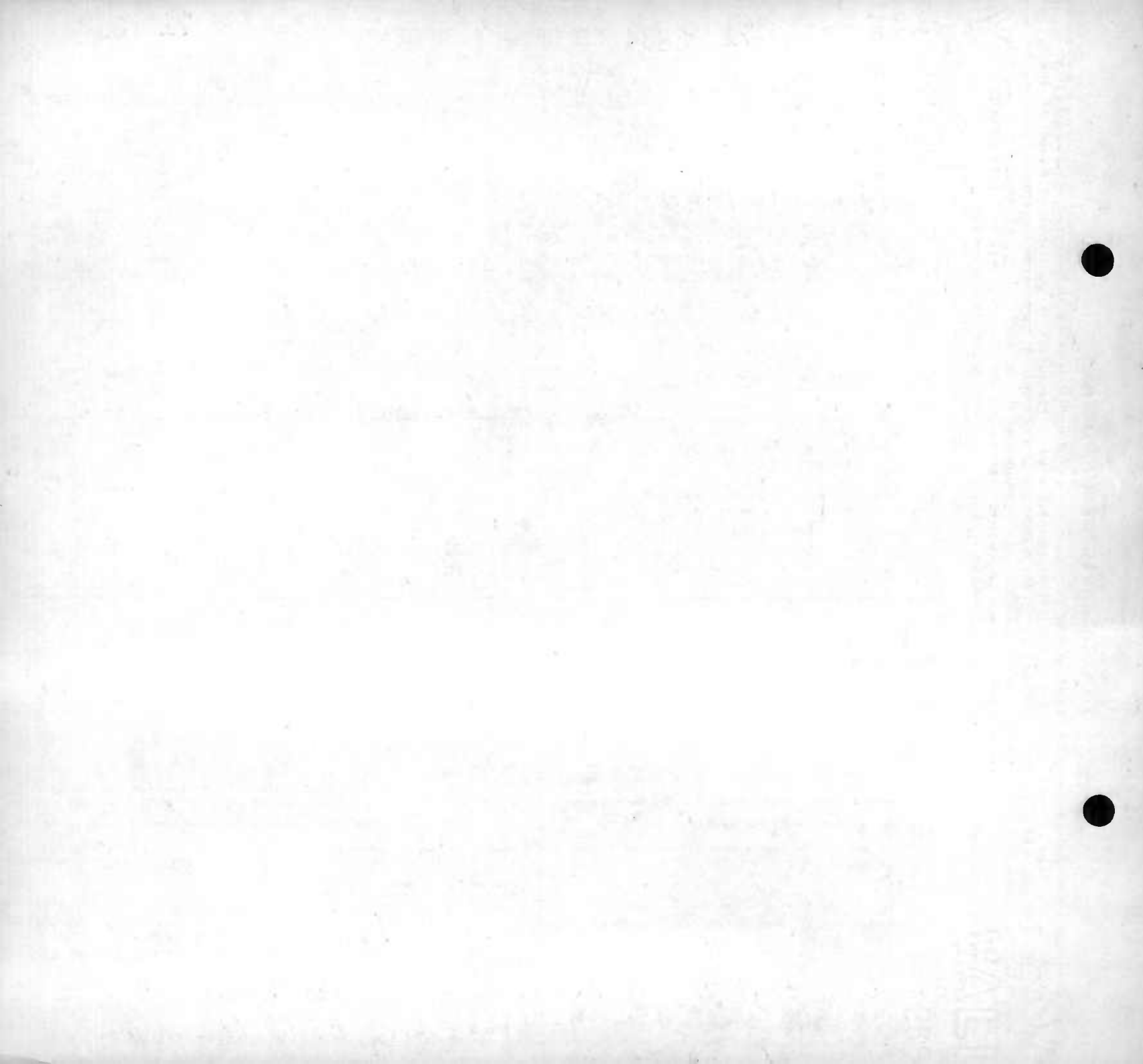
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3833
BIRTH NO. M-250		71 3833		
1. NAME OF DECEASED (Type or Print) ANNIE McCALIN		2. DATE AND HOUR OF DEATH 4/15/71 12:20 pm		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hosp		A. STATE MD. B. COUNTY Balto City		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4017 Liberty Ht		
5. SEX F	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/25/02	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Crisfield Md
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME U.S.A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Legume Tyson
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/12/41		CAUSE OF DEATH Ventricular fibrillation?		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio-vascular disease		
		(B) DUE TO, OR AS A CONSEQUENCE OF: Malnutrition, dehydration		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4-15-71 19 to 4-15-71 19 that (I) (we) lost saw the deceased alive on 4/15/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Juan Gan, MD		23B. DATE SIGNED 4/15/71		
23C. PHYSICIAN'S NAME (Type) JUAN G. GAN, MD		23D. ADDRESS 1203 Oak Croft Drive Lath, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-21-71	24C. NAME OF CEMETERY OR CREMATORY Int'l Lakewood Cent		24D. LOCATION (City, town, or county) (State) A.A. County Md
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Elroy O. Wilson		
		ADDRESS 4401		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3834
<div style="display: flex; justify-content: space-between;"> P-500 71 3834 CERTIFICATE OF DEATH </div>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) Bertha U. Payne			2. DATE AND HOUR OF DEATH Apr. 15th 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1512	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 003814 PAI L MAIL Rd.			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 3814 PAI L MAIL Rd	
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 21, 1893	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) BALTO. Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.A	
14. MOTHER'S MAIDEN NAME Sophie STANSBURY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-14-1714			17. INFORMANT Lavinia P. Gross ADDRESS SAME	
18. 702X CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Myocardial Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Cerebral Hemorrhage			(B) DUE TO, OR AS A CONSEQUENCE OF 3 Days	
			(C) Hypertension Heart Disease 2 1/2 weeks	
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5-1-71 to 4-15-71 , that (I) (we) lost saw the deceased alive on 4-14-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Richard H. Hunt			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Richard H. Hunt			23D. ADDRESS 1607 W. Millington Baltimore Md 21223	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-71		24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.
		24D. LOCATION Baltimore Md.		(State)
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Chas. D. Wilson ADDRESS 1000 Braniff Ave. BALTO. Md.



FUNERAL DIRECTOR: IMPORTANT

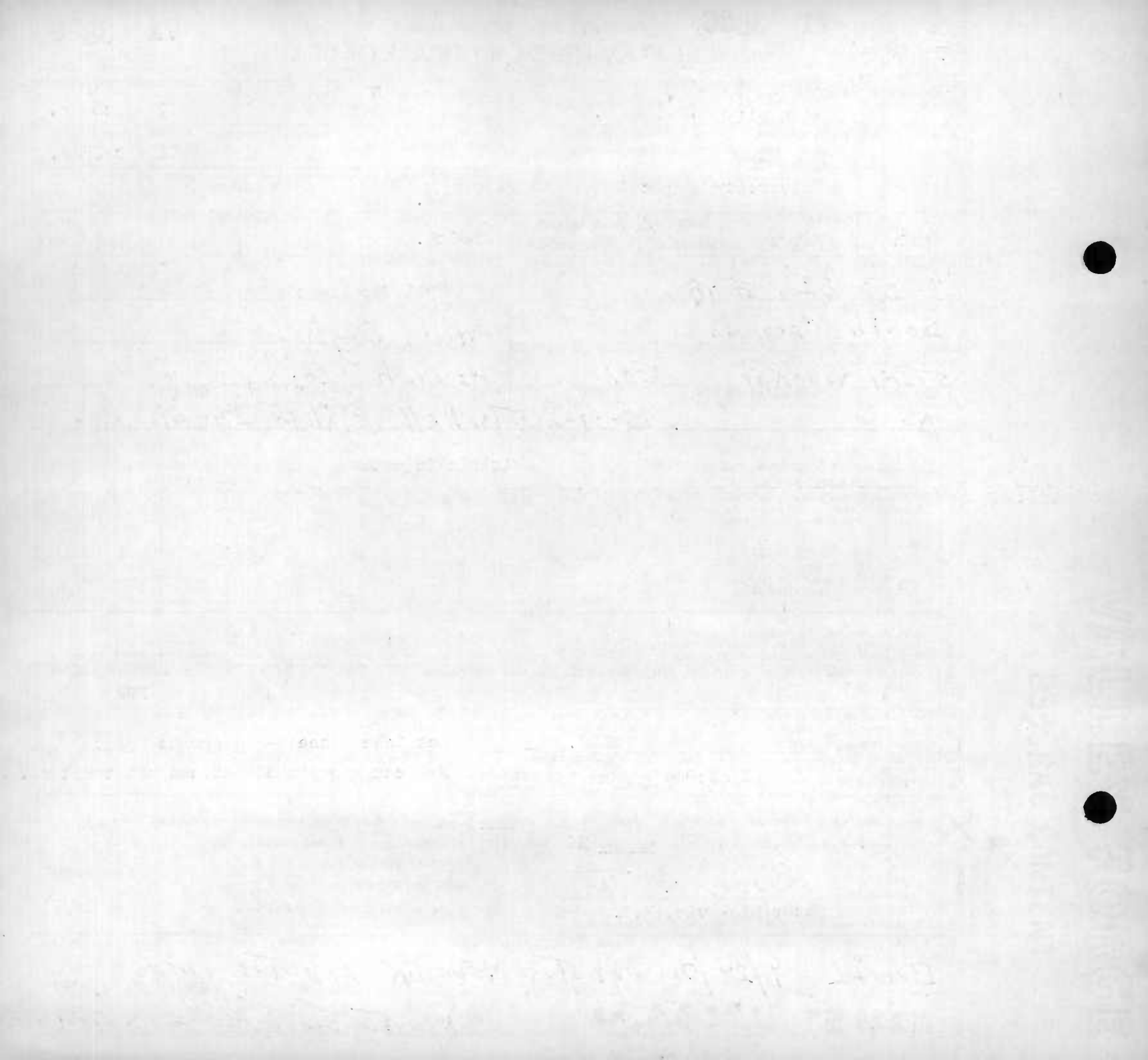
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3835	
BIRTH NO. H-452		1. NAME OF DECEASED (Type or Print) JOHNNY JAMES HOLMES		2. DATE AND HOUR OF DEATH 4/18/71 8²⁵/A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO, MD.			A. STATE Maryland B. COUNTY 906		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2713 Tivoly Avenue 21218		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-32	9. AGE (in years last birthday) 38	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Sylvester Holmes		14. MOTHER'S MAIDEN NAME Eleanora Smith		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH respiratory arrest (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. terminal uremia chronic nephritis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/22 19 71 to 4/18 19 71 that (we) last saw the deceased alive on 4/18 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Roll			23B. DATE SIGNED 4/18/71		
23C. PHYSICIAN'S NAME (Type) Joseph Roll			23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-23-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION A. A. County Md.		24E. NAME OF REGISTRAR Robert E. Taylor, Jr.		24F. FUNERAL DIRECTOR Edwitt H. 11297 Carroll St.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR		25C. ADDRESS	



71 3836 BALTIMORE CITY HEALTH DEPARTMENT 71 3836
E-524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. _____

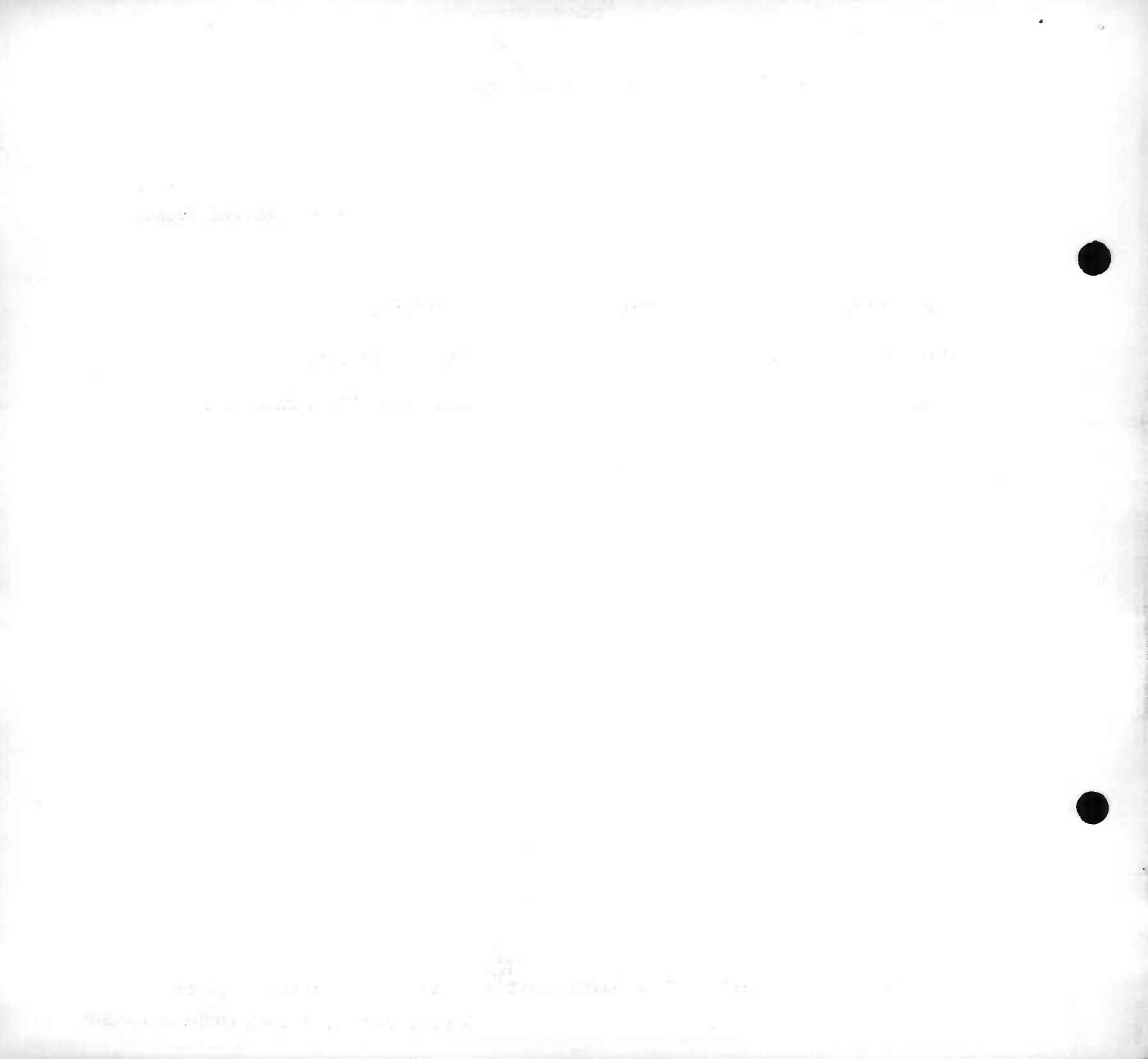
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joel English		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 19 71 3:56 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 19 71 3:56 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 906	
6. SEX male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-29-22		10. AGE (In years lost birthday) 48		E. STREET AND NUMBER 2911 The Alameda	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Will English	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		14B. KIND OF BUSINESS OR INDUSTRY STEEL		15. MOTHER'S MAIDEN NAME HANNAH Goings	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 248-34-2535		18. INFORMANT Isabell English	
19. E-9181 X		CAUSE OF DEATH Multiple injuries		ADDRESS 2911 Alameda	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BLDG.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Bethlehem Steel - Sparrows Point	
22D. TIME OF INJURY (APPROX.) 3 18 71 2:00p		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was pinned between two tractors.	
23.					
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Peter Lipkovic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Peter Lipkovic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/19/71	
ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/24/71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK.	
24D. LOCATION (City, town, or county) Arbutus, Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert C. Taylor, M.D.		25C. FUNERAL DIRECTOR William L. Elicker	
				ADDRESS N CAROLINE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 21 3837	
BIRTH NO. 71 3837		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) XXXXXXXXXXXXXXX ANGELINA BOVA		2. DATE AND HOUR OF DEATH 4-17-71 6:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 3002 Woodland Ave. 2798			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital of Baltimore		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER # 15 3200 Woodland Avenue			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-1900	9. AGE (in years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Joseph ?		14. MOTHER'S MAIDEN NAME Stella Scallia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph Bova 626 Aldsworth Rd	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>I (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of the</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> </div> </div>					
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-9-71 to 4-17-71 that (we) last saw the deceased alive on 4-17-71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodolph S. Victoria MD				23B. DATE SIGNED 4-17-71	
23C. PHYSICIAN'S NAME (Type) Rodolph S. Victoria MD				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Robert E. Garber, R.D.		25C. FUNERAL DIRECTOR ADDRESS WALTER DABROWSKI 1005 DUNDALK AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
REG. NO. 71 3838										
BIRTH NO. <u>R-152</u> 71 3838										
1. NAME OF DECEASED (Type or Print) <u>Robinson, Gertrude</u>					2. DATE AND HOUR OF DEATH <u>4/14/71</u> <u>7:00 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bolton Hill Nursing Center</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>603</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Center</u>					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <u>234 N. PATTERSON PARK AVE.</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-95</u>	9. AGE (in years last birthday) <u>75</u>	10. If Under 1 Yr. Months: <u>7</u> Days: <u>5</u>	11. If Under 24 Hrs. Hours: <u>7</u> Min. <u>5</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Nurse</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>			11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>		
13. FATHER'S NAME <u>Jacob Terber</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Admission Record</u>				ADDRESS	
18. CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerotic heart disease</u>					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial infarction</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>arteriosclerosis generalized</u>					(B) DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>					
					(C) <u>chronic from atherosclerosis</u> <u>years</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>—</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20A. AUTOPSY? (Yes or No) <u>—</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>—</u>				
22. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> 19 <u>70</u> to <u>4/14</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/14</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>ALLAN H. MACHT MD</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>4/15/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>					23D. ADDRESS <u>2 E Reed St Balto MD 21202</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/17/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Immortal Bur</u>			24D. LOCATION (City, town, or county) (State) <u>Balto City</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Gabley, M.D.</u>			25C. FUNERAL DIRECTOR <u>W. Beerman 6067 Half Rd</u>				

S-152

71 3839

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3839

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HENRY SPANGLER

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 227 S. Broadway

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 16, 1971

8:35 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

202

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

OCTOBER 25, 1908

10. AGE (In years lost birthday)

63

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

227 S. Broadway

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John J. Spangler

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cab Driver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Alvina Rode

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Geo Spangler 1114 High country Rd (4)

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Cirrhosis of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/16/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/19/71

24C. NAME OF CEMETERY or CREMATORY

Immanuel Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 20 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Paul Herman

ADDRESS

6067

Harford Rd

John J. Thompson
Chicago, Ill.
Thompson's Patent

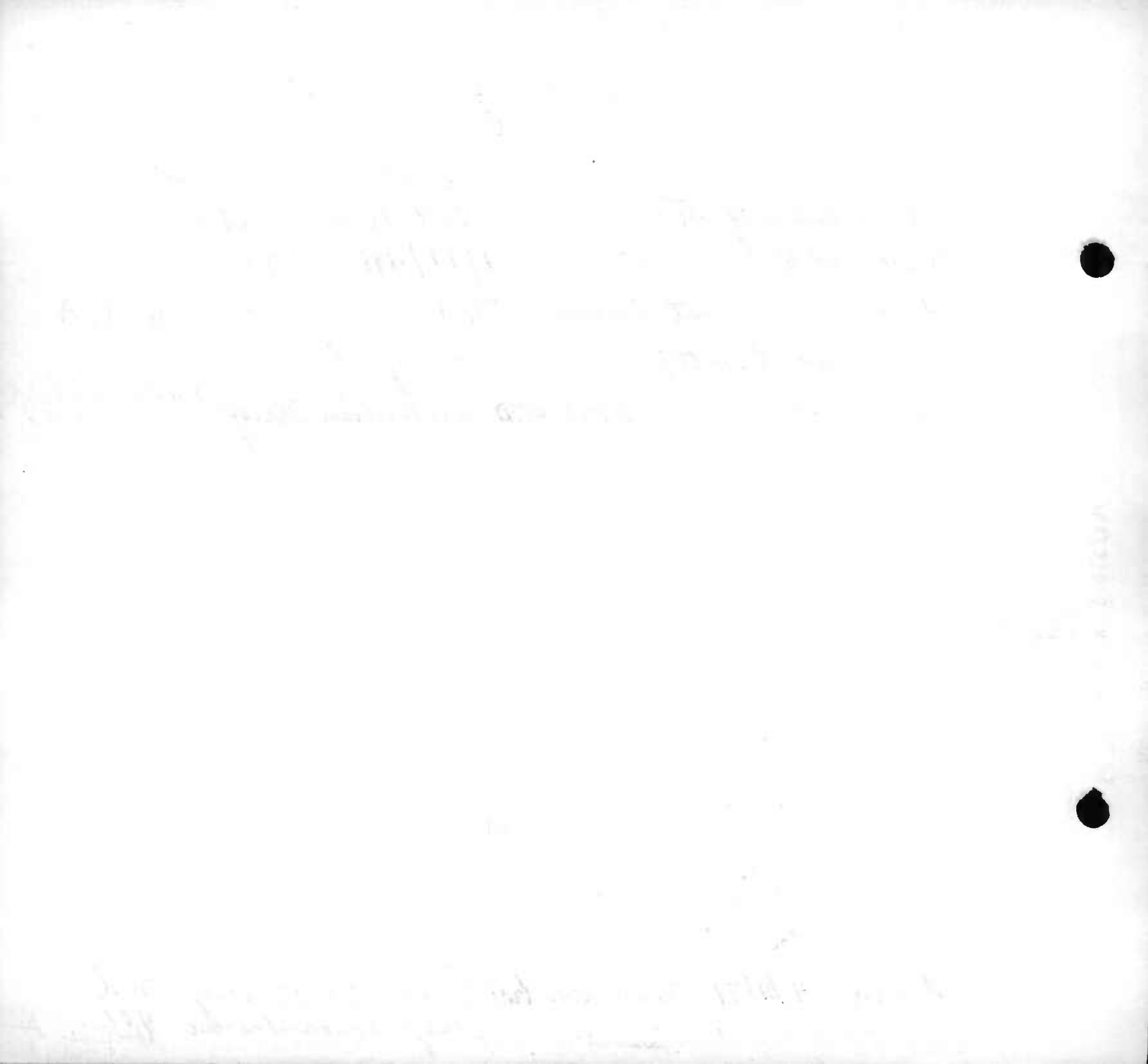
John J. Thompson
Chicago, Ill.

Patent Office
Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3840</u>	
BIRTH NO. <u>X-400</u>		71 3840		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Josephine C. Kelly</u>			2. DATE AND HOUR OF DEATH <u>4/18/71</u> <u>3³⁰ P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2101</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>764 Ramsay St.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>764 Ramsay St.</u>		
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/17/1898</u>	9. AGE <u>73</u> years (last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Crothy</u>			14. MOTHER'S MAIDEN NAME <u>Mary ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-03-06970</u>	17. INFORMANT <u>Mr. William Kelly</u> ADDRESS <u>3315 Mayfield Ave</u> <u>21207</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4/18/71</u> <u>Anterior-Septic C. V. A.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>not 8 hrs.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anterior-Septic C. V. A.</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 18</u> 19 <u>63</u> to <u>April 18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>March 21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry E. Kates</u>			23B. DATE SIGNED <u>4-19-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>HARRY E. KATES MD</u>			23D. ADDRESS <u>517 Scott St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/21/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION <u>Baltimore, md.</u>		24E. NAME OF FUNERAL DIRECTOR <u>John J. Egan & Son Inc.</u>		24F. ADDRESS <u>Hollins St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1971</u>		25B. NAME OF REGISTRAR <u>John J. Egan & Son Inc.</u>		25C. FUNERAL DIRECTOR <u>John J. Egan & Son Inc.</u>	



1

71 3841

BALTIMORE CITY HEALTH DEPARTMENT

S-563

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3841

BIRTH NO.

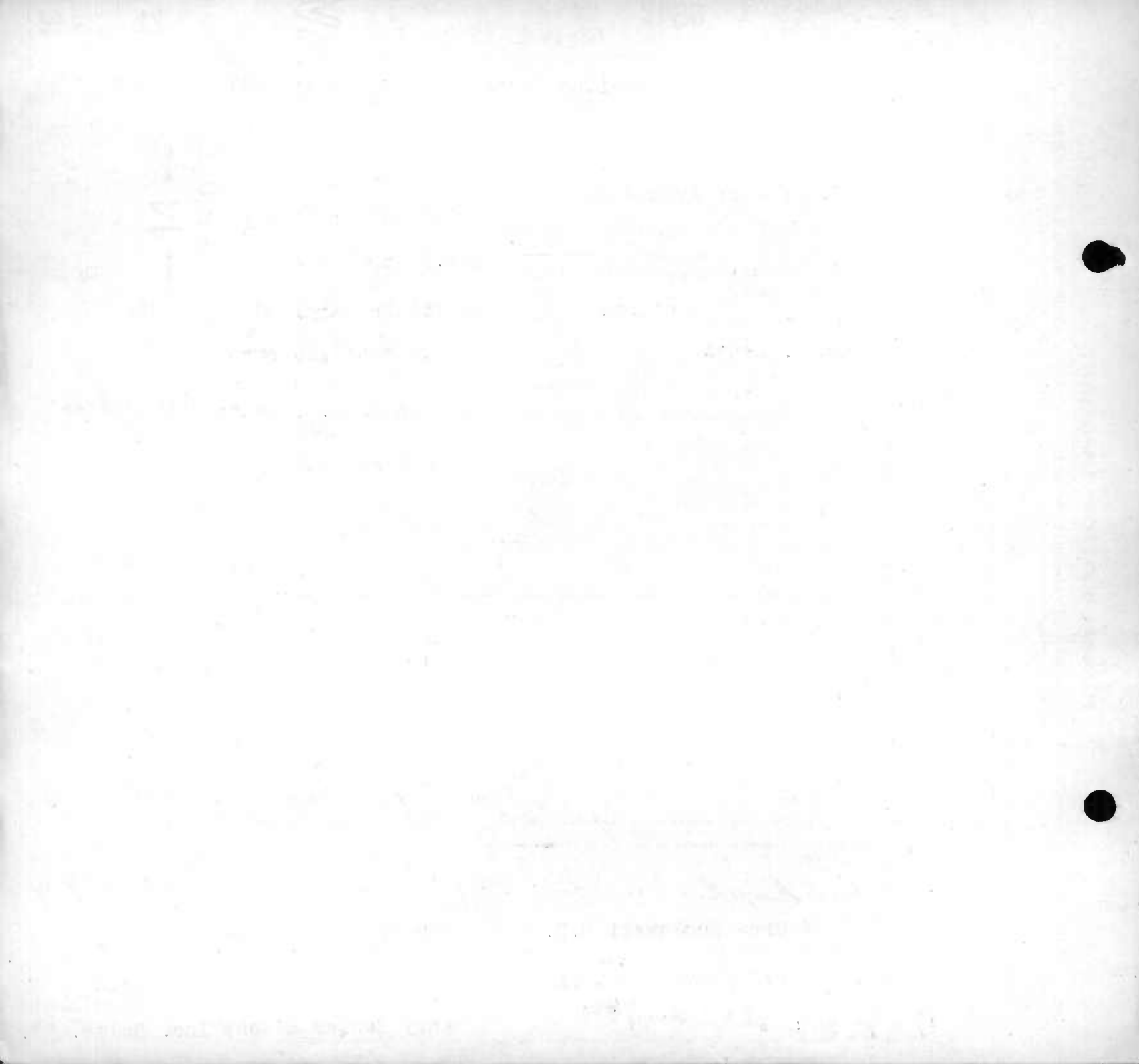
1. NAME OF DECEASED (Type or Print) Stanley Smertycha		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 12 71 2:52 p. M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years last birthday) 51		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Poland		E. STREET AND NUMBER 818 S. Kenwood Ave.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MICHAEL	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MASON		14B. KIND OF BUSINESS OR INDUSTRY CRYSTAL STONE	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT MRS. MARIA SMERTYCHA	
19. 41241		ADDRESS 818 S. Kenwood Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. DATE SIGNED: 4/13/71 EXAMINER'S NAME (Type): Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/71	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1971		25B. NAME OF REGISTRAR Raymond Kaczorowski	
25C. FUNERAL DIRECTOR Raymond Kaczorowski		ADDRESS 2525 East St	

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

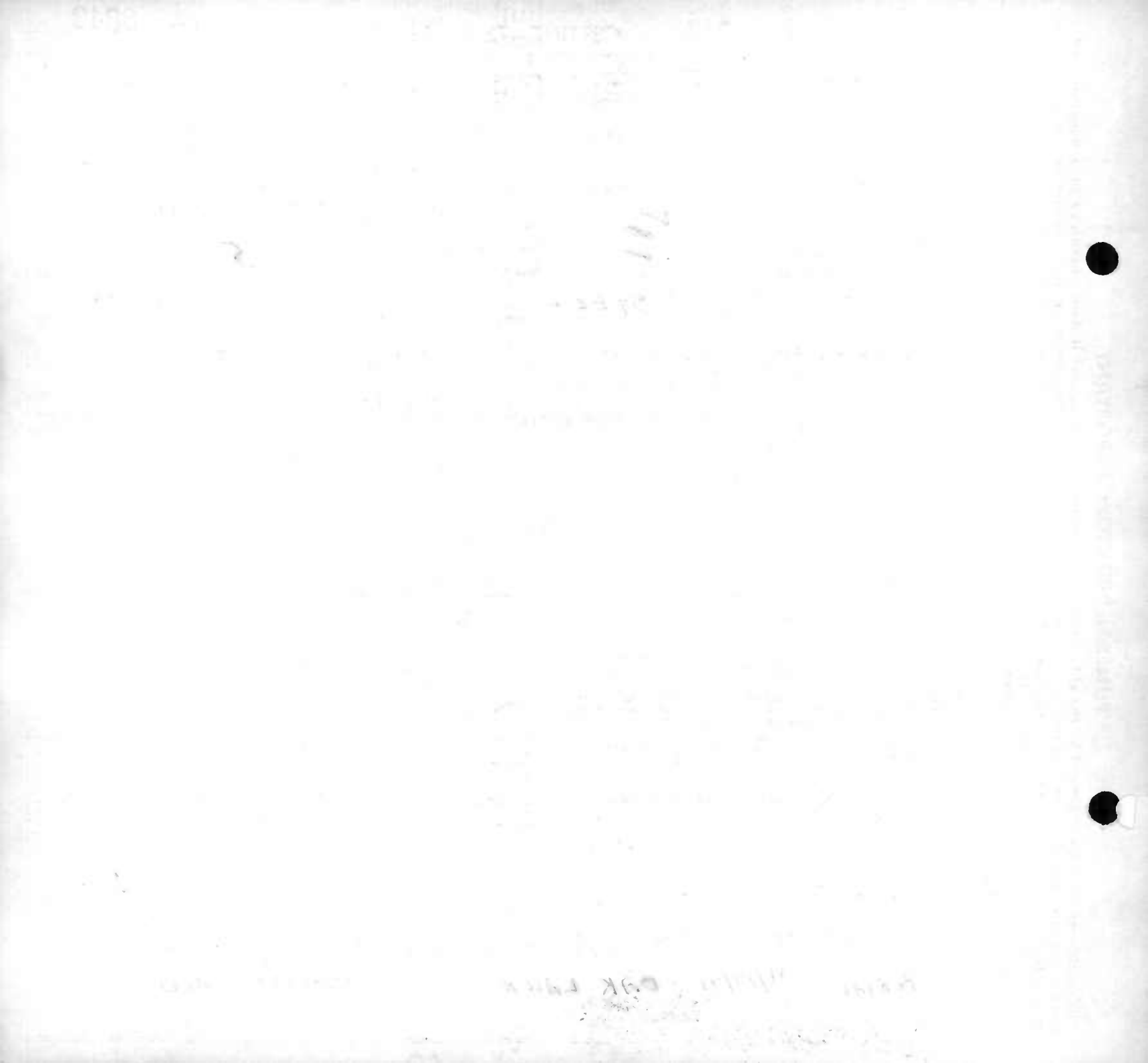
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	71 3842
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Wilhelmina Caroline Lentz		April 16, 1971		12:15 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 2313 Foster Avenue			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2313 Foster Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 3, 1888	82	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Retired		Baltimore Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John J. Lentz		Johanna Heuermann		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Mr Leonard J.P. Lentz 2313 Foster	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 2, 1969 to April 16, 1971, that (I) (we) last saw the deceased alive on April 15, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Andrew Kunkowski M.D.				12/18/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Andrew Kunkowski M.D.		2529 Eastern Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/19/1971		Oak Lawn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 21 1971		Robert E. Fisher		Henry Sander & Sons Inc. Balto. Md.	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
Baltimore Maryland		Baltimore Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 3843	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) WILLIAM J. DIDWALL				2. DATE AND HOUR OF DEATH APRIL 14 1971 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY BALTIMORE 5300 C. CITY OR TOWN WHITEMARSH D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 976 LORELEY BEAR ROAD.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-05	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? ? STEEL		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM DIDWALL				14. MOTHER'S MAIDEN NAME MARY YOCCA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - -		16. SOCIAL SECURITY NO. -		17. INFORMANT MEDICAL RECORD ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;"> (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Bronchopneumonia </div>			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-12 1971 to 4-14 1971 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 4-14 1971 and that (in my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
23A. SIGNATURE Lester A. Reid, M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-14-71	
23C. PHYSICIAN'S NAME (Type) LESTER A. REID, M.D. DEGREE				23D. ADDRESS UNION MEMORIAL HOSPITAL.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4/17/71	24C. NAME OF CEMETERY OR CREMATORY DAK LAWN	24D. LOCATION (City, town, or county) (State) BALTO. MD.				
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR J. E. ...		25C. FUNERAL DIRECTOR Connolly Funeral Home ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

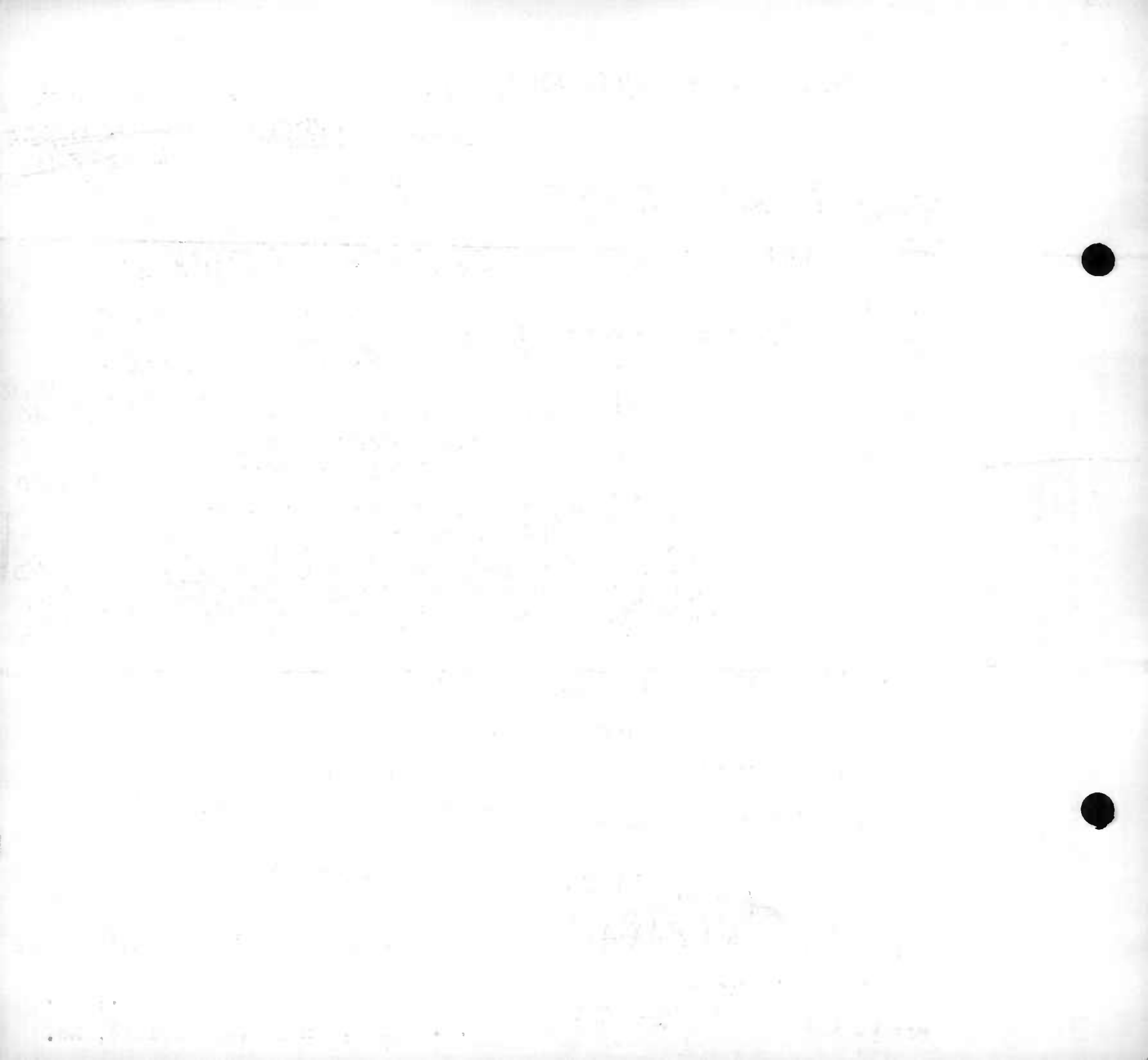
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 3844	
<div style="display: flex; justify-content: space-between;"> H-455 71 3844 </div>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HELLMAN MR CLARENCE J				2. DATE AND HOUR OF DEATH 04 14 71 11:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSP 35				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 948 THOMPSON BLVD			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/95	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CORK & SEAL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME WILLIAM H ELLMAN				14. MOTHER'S MAIDEN NAME MARY JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 213 01 0419		17. INFORMANT ADDRESS ELIZ. LAKE ABOVE			
18. 1621 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Emphysema				(A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF: (Rt upper lobe)			
				(C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3. 31 1971 to 4-14 1971 that (I) (we) last saw the deceased alive on 4 14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Prabir K. Bose				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4.14.71	
23C. PHYSICIAN'S NAME (Type) PRABIR. K. BOSE				23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/17/71		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR JOSE F. J. R.		25C. FUNERAL DIRECTOR J. G. CONNELLY, SEARS		ADDRESS 300 MA...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3845	
BIRTH NO. S-424		71 3845	
1. NAME OF DECEASED (Type or Print) SLAGLE BURNICE B.		2. DATE AND HOUR OF DEATH 4-17-71 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSP. OF BALTIMORE INC.		A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN Wootton D. INSIDE CITY Wootton YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 2, 1886 9. AGE (In years last birthday) 85 yrs. 3 mos. 15	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. BARNES		14. MOTHER'S MAIDEN NAME MARY E. Smith	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-48-9627 17. INFORMANT MILLARD F. SLAGLE ADDRESS 4203 BARRINGTON DR. BALTIMORE, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UNDETERMINED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNDETERMINED	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD Chronic Brain Syndrome Abdominal Mass Pre-renal Azotemia Fracture Femur		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Left Subcapital Fr. femur ASCVD Chronic Brain Syndrome Abdominal Mass Pre-renal Azotemia Fracture Femur	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 4-10-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hip	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NOTIFIED		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) UNDETERMINED	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) UNDETERMINED	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? UNDETERMINED	
22. I certify that (I) (this hospital) attended the deceased from 4-6-1971 to 4-17-1971 that (I) (we) last saw the deceased alive on 4-17-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE D. E. Suzara M.D.		23B. DATE SIGNED 4-17-71	
23C. PHYSICIAN'S NAME (Type) E. SUZARA M.D.		23D. ADDRESS SINAI HOSP. OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/1971	
24C. NAME OF CEMETERY OR CREMATORY McKendree		24D. LOCATION (City, town, or county) (State) Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR C.M. Waltz	
25C. FUNERAL DIRECTOR C.M. Waltz		25D. ADDRESS Box 326, Sykesville, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

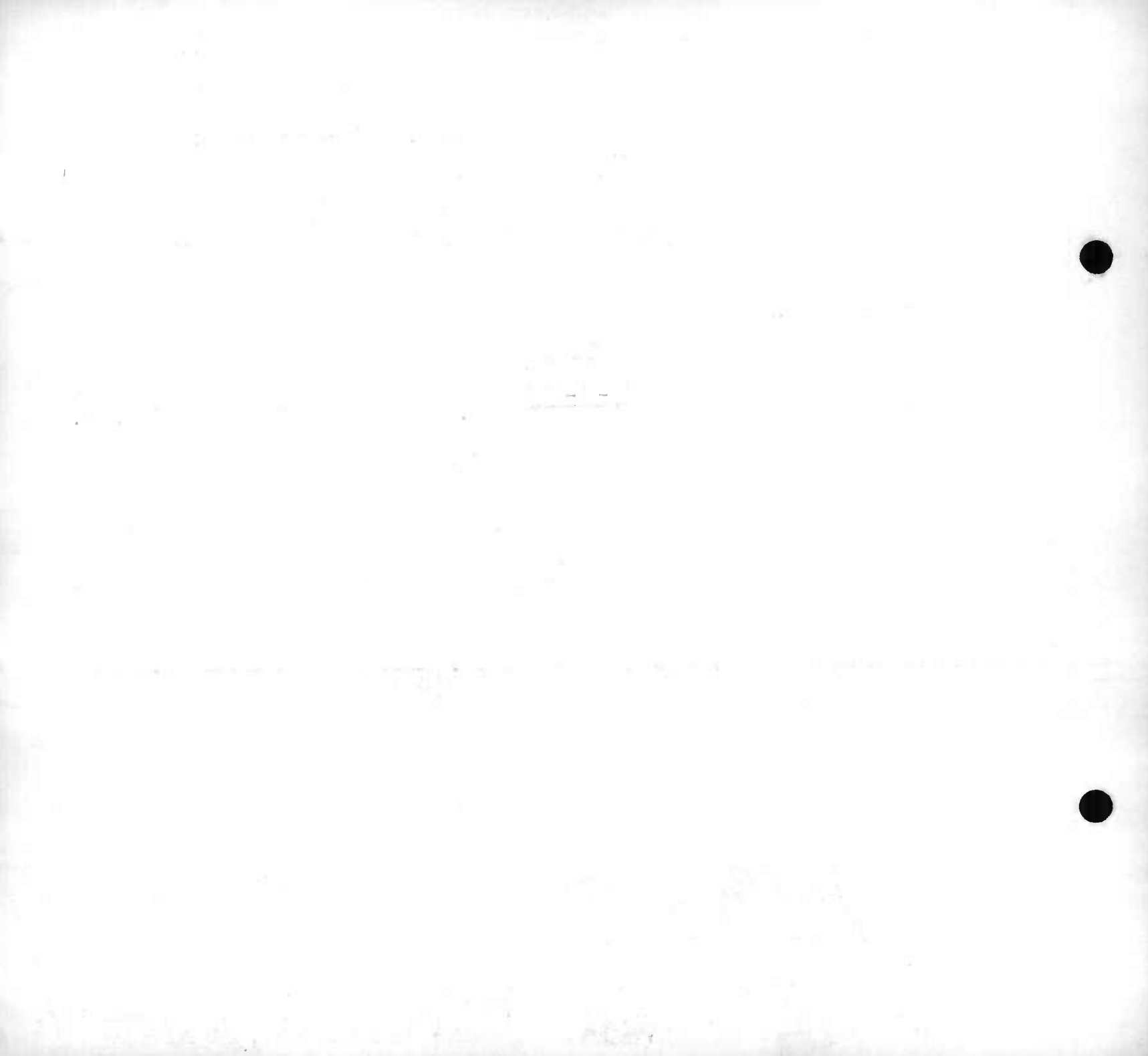
M-320 71 3846		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3846	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mathias, Laura E.</i>		2. DATE AND HOUR OF DEATH <i>4/19/71 8:05 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If in hospital or institution, give street address or location) <i>4-23-71 44 Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1307</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>03-08-89</i> 9. AGE (in years last birthday) <i>82</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i> 12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Peter S. Slingerland</i>		14. MOTHER'S MAIDEN NAME <i>Rosalie Flester</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>705-104803</i>		17. INFORMANT <i>Virginia Newberry</i>		ADDRESS <i>417 Warren Rd Cockeysville, Md</i>	
18. <i>412.4 I</i> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		(A) IMMEDIATE CAUSE <i>A cut heart attack</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <i>A-S-C-U-D</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <i>osteoporosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>4/12/71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/6/71</i> to <i>4/19/71</i> that (I) (we) last saw the deceased alive on <i>4/18/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>I. Chail</i>		23B. DATE SIGNED <i>4/19/71</i>		23C. PHYSICIAN'S NAME (Type) <i>ISSAM E CHEIKH</i>	
23D. ADDRESS <i>Union Memorial Hospital</i>		23E. DATE <i>4-22-1971</i>		23F. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill</i>	
23G. LOCATION <i>Lanaw, Maryland</i>		23H. DATE REC'D BY HEALTH DEPT. <i>APR 21 1971</i>		23I. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>	
23J. FUNERAL DIRECTOR <i>Wm. Cook & Brooks Towson</i>		23K. ADDRESS <i>1050 York Rd Towson, Md</i>		23L. DATE SIGNED <i>4/19/71</i>	

VS 153 4-23-71 M.N.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 3847</u>	
BIRTH NO. <u>S-326 71 3847</u>				1. NAME OF DECEASED (Type or Print) <u>GEORGE SWEITZER</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>APRIL 17, 1971 1:30 A.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ALLEGANY</u> C. CITY OR TOWN <u>FROSTBURG</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>RT #1 BOX 93</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02/27/20</u>		9. AGE (In years last birthday) <u>51</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor-Twisting</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>CELANESE CORP.</u>		11. BIRTHPLACE (State or foreign country) <u>SHAFT, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>ISAAC SWEITZER</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES FILER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, month, year, unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 2</u>				16. SOCIAL SECURITY NO. <u>214-07-0869</u>		17. INFORMANT <u>Mrs. Dorothy Mae Sweitzer Frostburg, Md.</u>	
18. <u>450X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u> (B) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Suspected pulmonary emboli</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u> <u>2-3 days</u> <u>? days</u>	
19A. DATE OF OPERATION <u>3 APRIL 11, 1971</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>HYPOKIA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>17 April</u> 19 <u>71</u> to <u>17 April</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>17 April</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John F. Rogers M.D.</u>				23B. DATE SIGNED <u>April 17, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>John F. Rogers, M. D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/20/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>	
24D. LOCATION <u>Frostburg Allegany Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>			
25B. NAME OF REGISTRAR <u>John F. Rogers</u>				25C. FUNERAL DIRECTOR <u>Hafer Funeral Service, 230 Balto Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

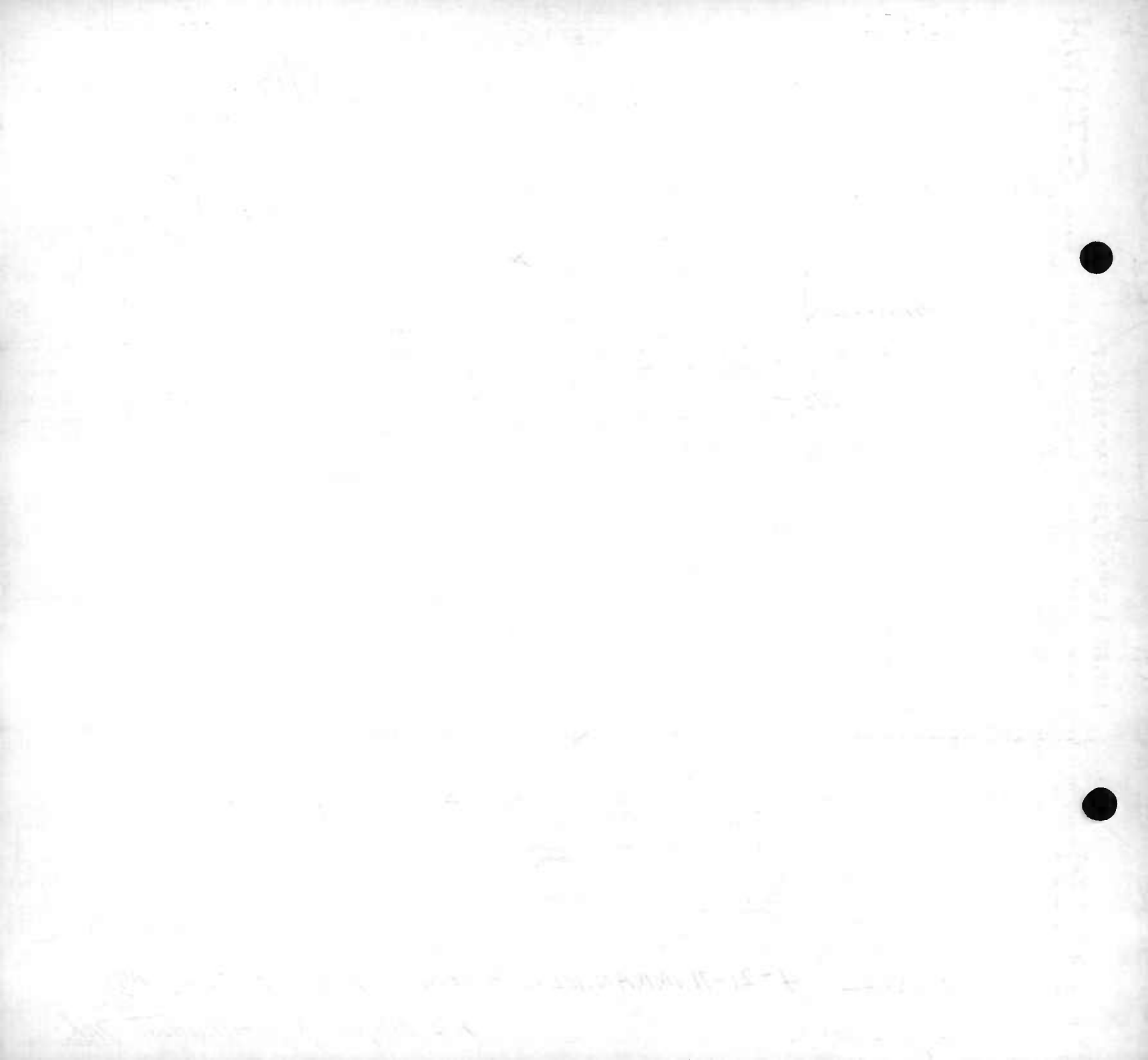
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 71 3848									
BIRTH NO. L-520 71 3848									
1. NAME OF DECEASED (Type or Print) THOMAS Clements LYNCH					2. DATE AND HOUR OF DEATH 4/19/71 6:45 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 827 Linden Avenue					A. STATE Md.				
					C. CITY OR TOWN Baltimore				
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 321 East 33rd Street				
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1900		9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Harford Furnace, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Daniel J. Lynch					14. MOTHER'S MAIDEN NAME Anna T. Moran				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. 218-18-7528		17. INFORMANT Miss Regina Lynch, 321 E. 33rd St., Baltimore		
18. 4-27-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) ACIDOSIS HYPOXIA, ACUTE PULM. EDEMA DUE TO, OR AS A CONSEQUENCE OF: (C) CHF, PNEUMONIA				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6:40 PM				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 4/17 19 71 to 4/19 19 71 that (we) last saw the deceased alive on 4/19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.									
23A. SIGNATURE J M Pardo					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-19-71		
23C. PHYSICIAN'S NAME (Type) JUAN M. PARDO					23D. ADDRESS MGT				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 22, 1971		24C. NAME OF CEMETERY or CREMATORY St. Francis Cemetery		24D. LOCATION (City, town, or county) (State) Abingdon Harford Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR J. R. McCon...		25C. FUNERAL DIRECTOR J. R. McCon...		ADDRESS P. B...			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

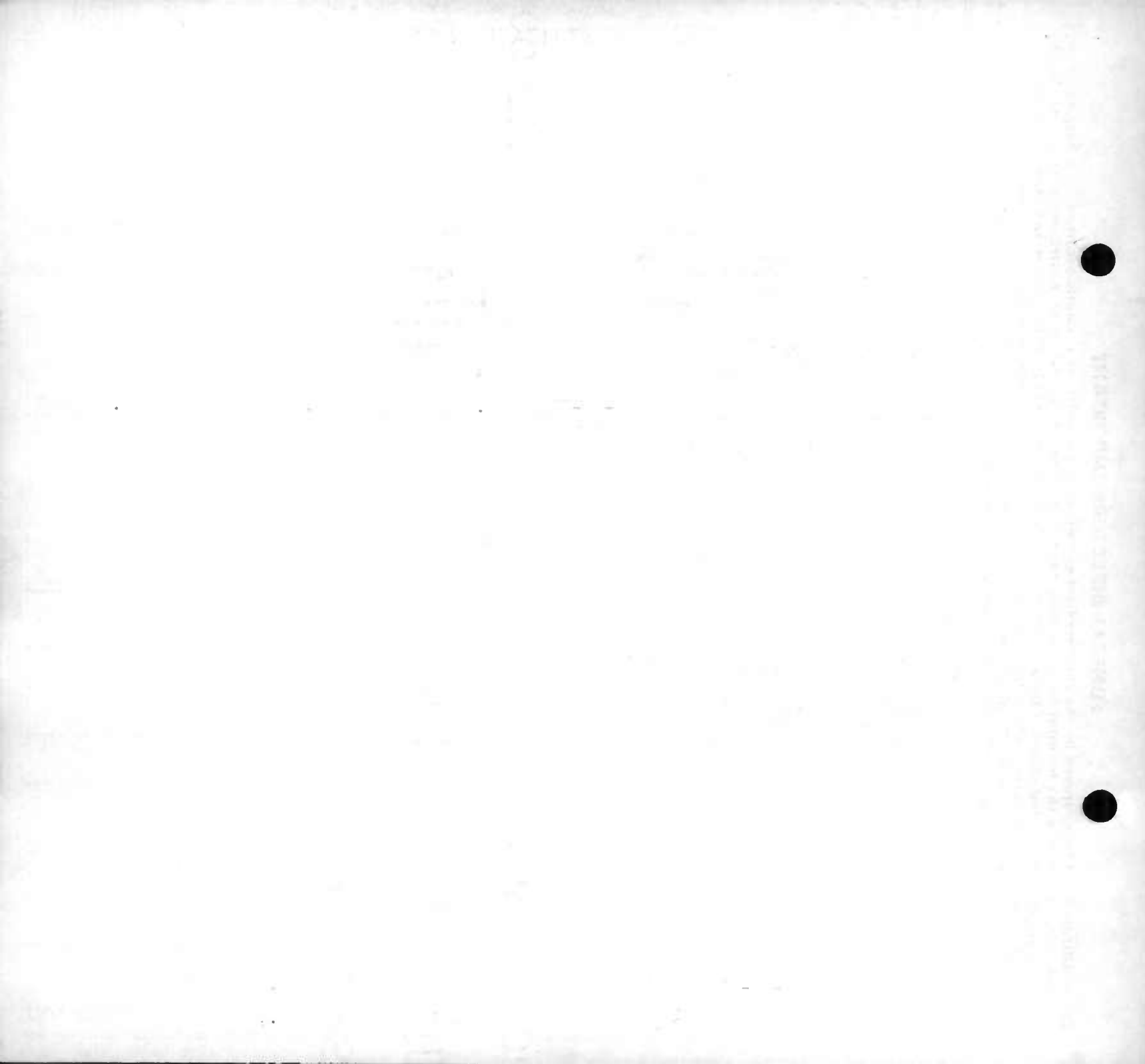
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3849	
<div style="display: flex; justify-content: space-between;"> L-252 71 3849 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) MR LOOKINGBILL, EDWARD H		2. DATE AND HOUR OF DEATH 04/18/1971 10:25 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 831			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2208 KENTUCKY AVENUE			
5. SEX M.	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 01-05-35	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HARVEY LOOKINGBILL		14. MOTHER'S MAIDEN NAME ANNA M. TRUMP			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADMISSION HISTORY CHART U.M. HOSP.	
18. 7-22-01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBROVASCULAR ACCIDENT (B) CONGESTIVE HEART FAILURE (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH KM			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 04-15-1971 to 04-18-1971 that (I) (we) last saw the deceased alive on 04-18-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rausch		23B. DATE SIGNED 04-18-1971		23C. PHYSICIAN'S NAME (Type) DR R. RAO	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-21-71		24C. NAME of CEMETERY or CREMATORY IMMANUEL LUTH. CEM.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR J. E. Taylor, Jr.		25C. FUNERAL DIRECTOR J. E. Taylor, Jr.	
24D. LOCATION (City, town, or county) (State) MANCHESTER, MD		25D. ADDRESS WATKINSON, MD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

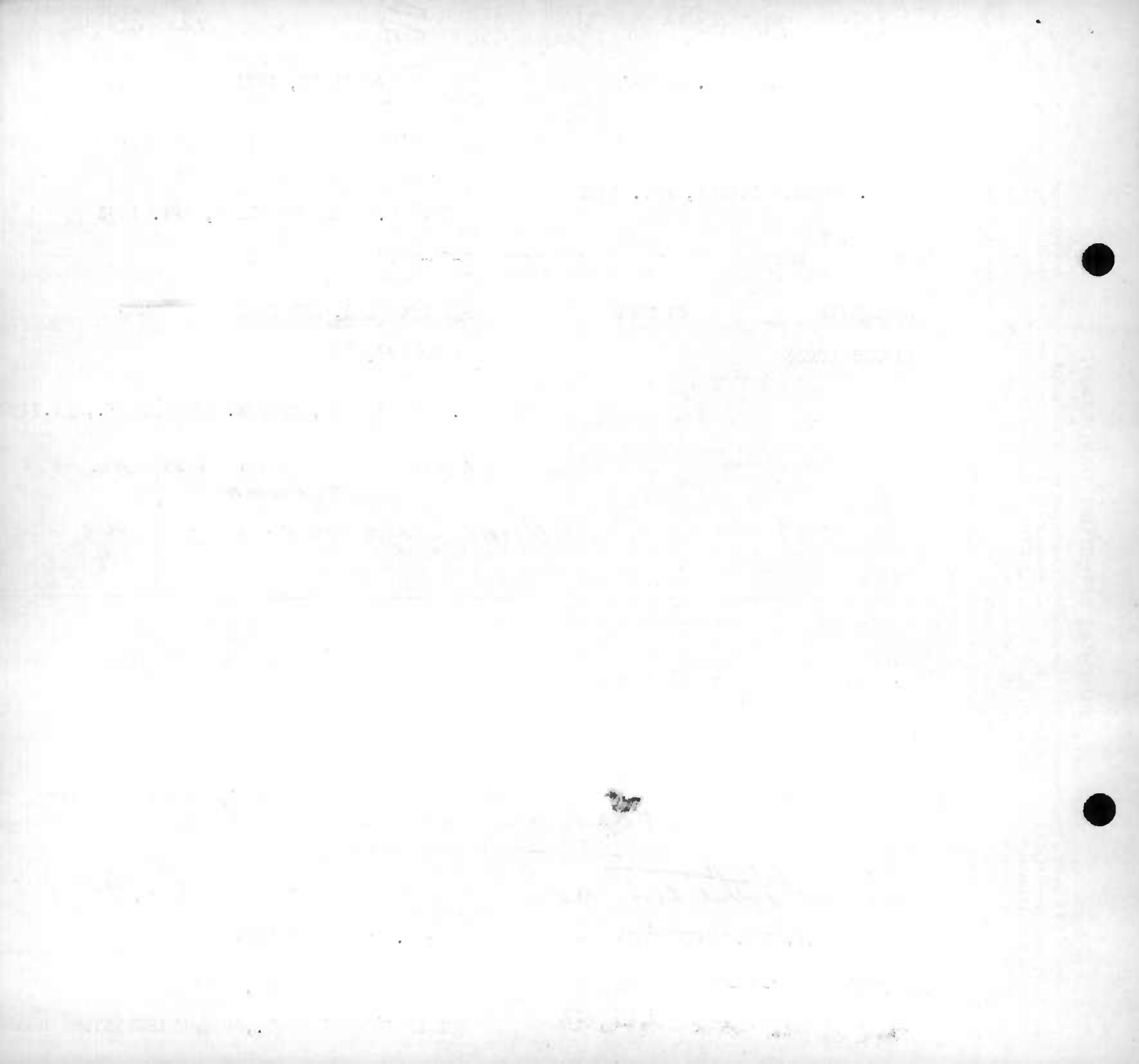
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 3850	
BIRTH NO. 0-552 71 3850				1. NAME OF DECEASED (Type or Print) <i>OMANSKY, Harry</i>		2. DATE AND HOUR OF DEATH <i>4-19-71 10 AM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2717</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>425 Sinai Hospital of Baltimore</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>Concord Apt. 1501 W. Baltimore</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-15-90</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BARBER</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>SHOP</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>
13. FATHER'S NAME <i>JOSEPH OMANSKY</i>				14. MOTHER'S MAIDEN NAME <i>SEEMA ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>213-18-7721</i>		17. INFORMANT ADDRESS <i>MR. JOSEPH OMANSKY, 6208 IVYMOUNT RD. #21208</i>		
18. <i>43691</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Antecedent Causes</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASCVD; Ischemia</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>probably brainstem</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>4-13</i> 19 <i>71</i> to <i>4-15</i> 19 <i>71</i> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>4-19</i> 19 <i>71</i> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <i>Rodolfo S. Victoria MD</i> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-19-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rodolfo S. Victoria MD</i> DEGREE				23D. ADDRESS <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-20-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>WORKMEN CIRCLE</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 21 1971</i>				25B. NAME OF REGISTRAR <i>W. E. Gentry JR.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

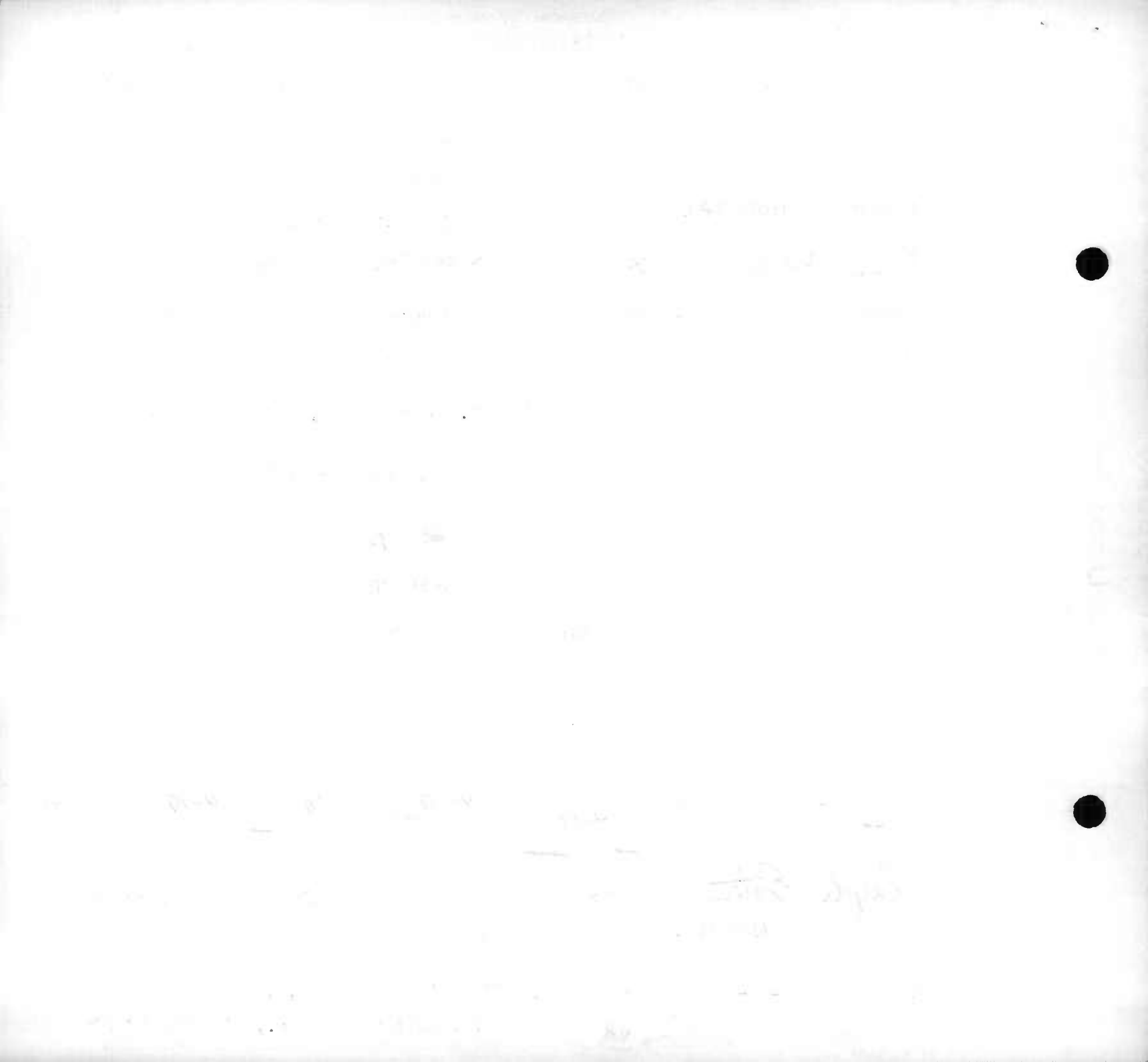
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3851	
E-255 71 3851				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LILLIAN G. EISEMAN				2. DATE AND HOUR OF DEATH APRIL 18, 1971 11. 9 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3900 N. CHARLES STREET, APT. 1402				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3900 N. CHARLES STREET, APT. 1402	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-1908	9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW ROCHELLE, NEW YORK	
13. FATHER'S NAME EDWARD GROSS				14. MOTHER'S MAIDEN NAME CORA WALDHEIMER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. LEE EISEMAN, 3900 N. CHARLES ST., APT. 1402	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE CARCINOMA METASTASES DUE TO, OR AS A CONSEQUENCE OF: TO LUNG	
				(B) CARCINOMA CERVIX DUE TO, OR AS A CONSEQUENCE OF: 1963	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 1963		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED C.A. of Cervix		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1 1971 to April 18 1971, that (I) (we) last saw the deceased alive on April 18 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Whitehouse M.D.				23B. DATE SIGNED 4-19-71	
23C. PHYSICIAN'S NAME (Type) SAMUEL WHITEHOUSE				23D. ADDRESS 3900 N. CHARLES STREET	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 4-20-71		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3852</u>	
<div style="display: flex; justify-content: space-between;"> B-250 71 3852 B-250 71 3852 </div>					
1. NAME OF DECEASED (Type or Print) <u>REGINA BIEGUN</u>		2. DATE AND HOUR OF DEATH <u>4-19-71</u> <u>4:45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>2730</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3306 NERAK ROAD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>X-X-X</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>279-167524</u>		17. INFORMANT <u>MRS. MIGNON SOBER, 3306 NERAK ROAD #21208</u>			
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>AGI bleeding, SEVERE DEPRESSION</u>					
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner examined) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>4-9</u> 19 <u>71</u> to <u>4-19</u> 19 <u>71</u> that (1) <u>was</u> last saw the deceased alive on <u>4-19</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>was</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>Ralph Epstein MD</u>		23B. DATE SIGNED <u>4-19-71</u>		23C. PHYSICIAN'S NAME (Type) <u>RALPH EPSTEIN</u>	
23D. ADDRESS <u>SINAI</u>		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4-20-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>PROGRESSIVE RUDOMER VEREIN</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	
25D. ADDRESS		25E. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

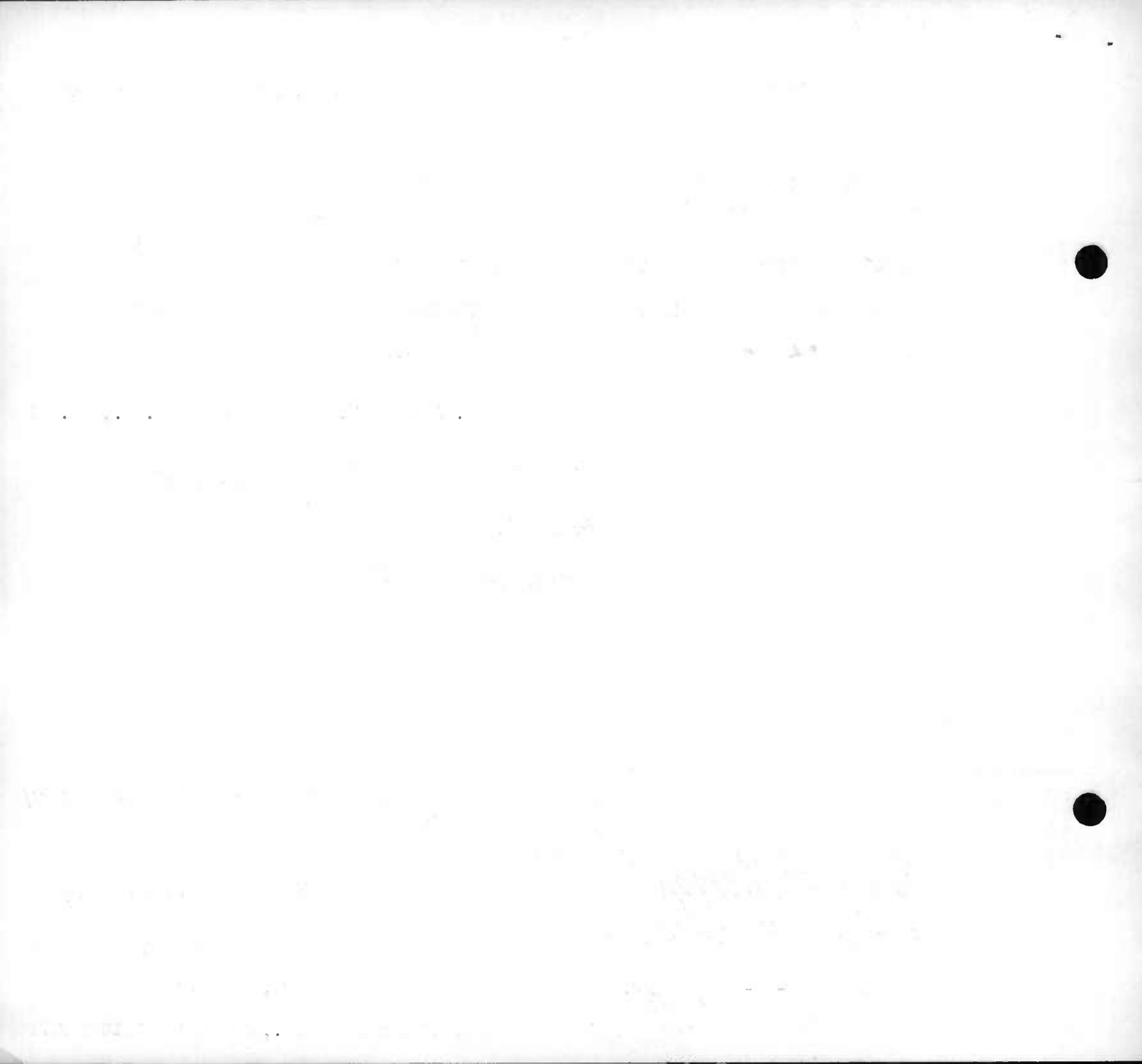
BALTIMORE CITY HEALTH DEPARTMENT				71 3853		REG. NO. 71 3853	
BIRTH NO. <u>C-500</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>COHEN, REBECCA</u>				2. DATE AND HOUR OF DEATH <u>4/19/1971</u> <u>10:30</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTO</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>2716</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4613 PK. Heights Ave #15</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/88</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		
13. FATHER'S NAME <u>WILLIAM DAVID DVORINE</u>			14. MOTHER'S MAIDEN NAME <u>ROSE ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MR. WILLIAM COHEN, 3806 GLENGYLE AVE. #21215</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.41-250.9</u>				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus, Recto-vesical fistula</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> 19 <u>71</u> to <u>4/19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/19</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Petsas M.D.</u>				23B. DATE SIGNED <u>4/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>ANDREAS A. PETSAS M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>4-20-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>KNESSETH ISRAEL ANSHE KOLK WOLYN, BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	

In and out NH for
a number of yrs.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-246 71 3854 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 71 3854 </div>			
1. NAME OF DECEASED (Type or Print) LENA MISLER		2. DATE AND HOUR OF DEATH APRIL 18, 1971 10¹⁵ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) EDGEWOOD NURSING HOME BELVEDERE & BELLONA AVENUES		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1509 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2904 LOUDON AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1882
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 88 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? BROOKMAN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS. SARA LEVY, 6964 MILBROOK PK. DR., APT. T 1		ADDRESS	
18. 413.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MITRAL Insufficiency - Myocarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. H.C.V.D. A.S.-H.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 13 1970 to April 18 1971 that (I) (we) last saw the deceased alive on April 17 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <input checked="" type="checkbox"/>			
23A. SIGNATURE Anthony F. Carozza		23B. DATE SIGNED 4-18-1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Anthony F. CAROZZA		5217 YORIS Rd Baltimore 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4-20-71	ANSHE EMUNAH	BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Jacob E. Gable, R.C.	
25C. FUNERAL DIRECTOR		ADDRESS	
SOL LEVINSON & BROS., 6010 REISTERS TOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3855
BIRTH NO. 1. NAME OF DECEASED (Type or Print) SARAH HOLZMAN		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> APRIL 19, 1971 5:40 A.M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 JEWISH CONVALESCENT HOME 4601 PALL MALL ROAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 3618 FOREST PARK AVENUE </div> <div style="width: 35%;"> B. COUNTY 1538 D. INSIDE CITY LIMITS? <div style="display: flex; justify-content: space-around;"> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> </div> </div>		
5. SEX <div style="display: flex; justify-content: space-around;"> FEMALE WHITE </div>	6. RACE <div style="display: flex; justify-content: space-around;"> WHITE </div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <div style="display: flex; justify-content: space-around;"> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> </div>	8. DATE OF BIRTH 8-15-1883	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND
13. FATHER'S NAME ? BITTMAN		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. WILLIAM HOLZMAN, 6918 FIELDCREST RD.
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> CAUSE OF DEATH Cerebral of femoral arteriosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: </div> </div>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED <div style="display: flex; justify-content: space-around;"> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1951 19 to 4/19/71 19 that (I) (we) last saw the deceased alive on 3/13/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.		
23A. SIGNATURE Milton B. Kirsh		23B. DATE SIGNED 4/19/71		23C. PHYSICIAN'S NAME (Type) MILTON B. KIRSH
23D. ADDRESS 4000 W. NORTHERN PKWY		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 4-20-71		24C. NAME OF CEMETERY or CREMATORY TIFERETH ISRAEL ANSHE SFARD		
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		
25B. NAME OF REGISTRAR Robert E. Galtman, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
71 3856					71 3856				
BIRTH NO. 1-635					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
JORDAN, Maitland St.					4/18/71 3:10 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL					A. STATE Md. BALTIMORE CITY				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY				
X3					C. CITY OR TOWN CITY				
5. SEX M					D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
6. RACE W					E. STREET AND NUMBER 5208 Ritchie Hwy.				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 12-03-07				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					9. AGE (In years last birthday) 63				
Painter					11. BIRTHPLACE (State or foreign country) Md.				
10B. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Milton Jordan					14. MOTHER'S MAIDEN NAME Mary Elizabeth Sanders				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 214 03 2138				
17. INFORMANT Mrs. Thelma Taylor					ADDRESS Same				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 192.9 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: META STATIC DISEASE 3 months A.S.C. V.D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CONGESTIVE HEART FAILURE. 6 months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					22. I certify that (I) (this hospital) attended the deceased from 3/30/71 to 4/18/71 that (I) (we) last saw the deceased alive on 4/18/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Harjit Singh M.B.R.S.					23B. DATE SIGNED 4/18/71				
23C. PHYSICIAN'S NAME (Type) HARJIT SINGH M.B.R.S.					23D. ADDRESS 3001 S. HANOVER ST. BALTO MD 21225				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/21/71				
24C. NAME of CEMETERY or CREMATORY Cedar Hill					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971					25B. NAME OF REGISTRAR George J. Gonce				
25C. FUNERAL DIRECTOR George J. Gonce					ADDRESS 4001 Ritchie Hwy. Baltimore, Md. 21225				

10/20/71 Metastatic Disease
probably G.D. Tract -
primary unknown

Additional Information from letter from
South Ballo Gen Hosp - Filed in Bur of
Geostatistics

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN W. KELBAUGH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00407 S. Norris Street				3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1971 2:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1902					
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-16-1908		10. AGE (In years last birthday) 63 62	E. STREET AND NUMBER 407 S. Norris Street		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Henry Ashton Kelbaugh		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Fanny Clark	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 216-09-9228		18. INFORMANT ADDRESS Henry Kelbaugh-74 Kay Dr. Milford, Ohio	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Arteriosclerotic cardiovascular disease	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Armocost Funeral Chapel - 4600 Liberty, Hts	

1000-22

1000-22

1000-22

1000-22

1000-22

1000-22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3858</u>	
BIRTH NO. <u>H-640</u>		71 3858			
1. NAME OF DECEASED (Type or Print) <u>Ella Virginia Harle</u>			2. DATE AND HOUR OF DEATH <u>April 16, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Baltimore General</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>121 E. West Street</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1880</u>	9. AGE (in years last birthday) <u>91</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Sidney White</u>		
14. MOTHER'S MAIDEN NAME <u>Emily V Brunington</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NO</u>			17. INFORMANT ADDRESS <u>Nellie Cook-2039 Grinnalds Avenue</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A SCVD.</u> <u>ANEMIA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 21</u> 19 <u>63</u> to <u>APRIL 16</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>APRIL 13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John F. Hartman M.D.</u>				23B. DATE SIGNED <u>April 19, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN F. HARTMAN M.D.</u>				23D. ADDRESS <u>422 MEDICAL ARTS BLDG 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-20-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>			
25B. NAME OF REGISTRAR <u>John F. Hartman, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Armocost Funeral Chapel - 4600 Liberty Hts</u>			

1. 10. 1912

2. 10. 1912

3. 10. 1912

4. 10. 1912

5. 10. 1912

6. 10. 1912

7. 10. 1912

8. 10. 1912

9. 10. 1912

10. 10. 1912

11. 10. 1912

12. 10. 1912

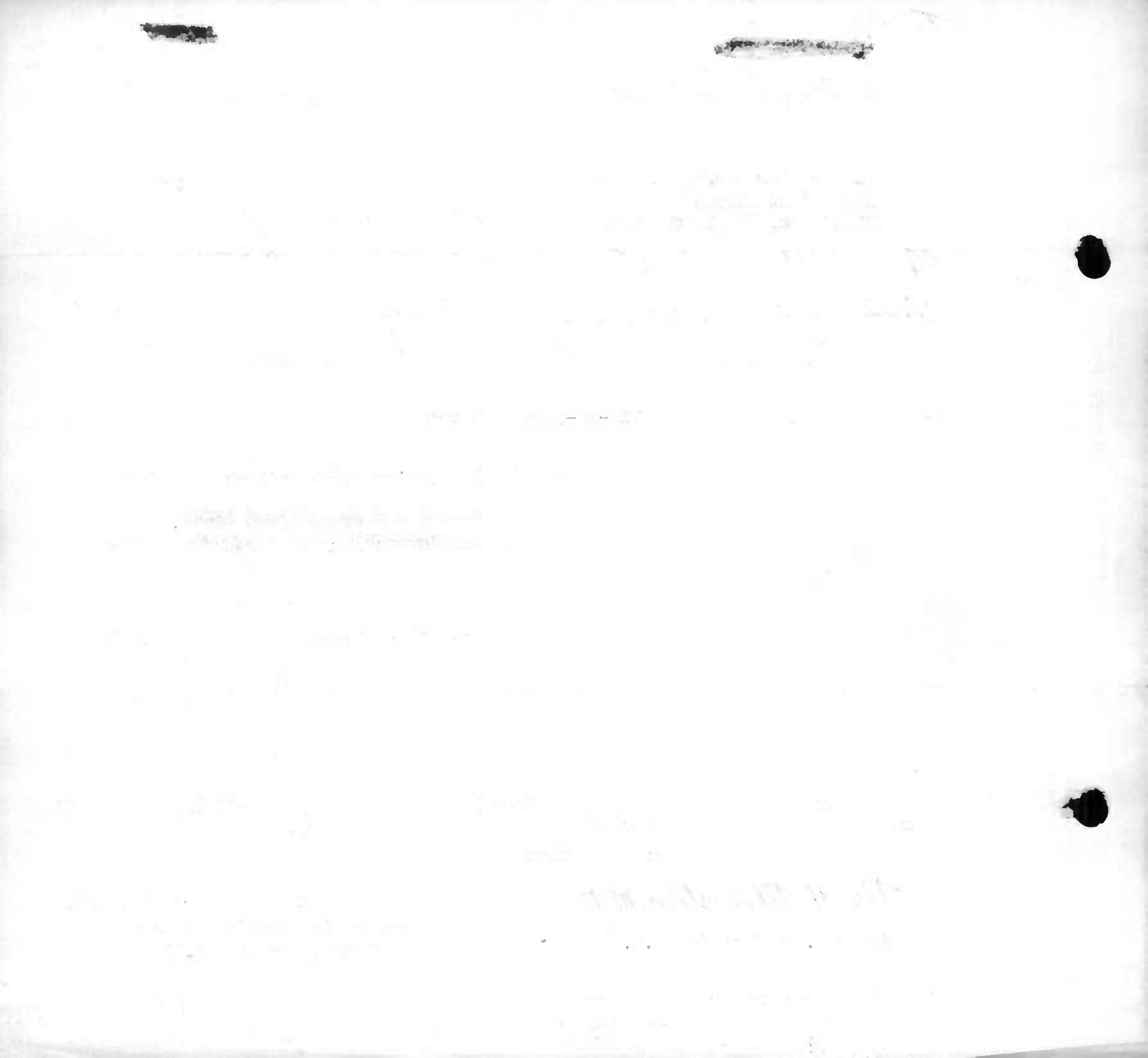
13. 10. 1912

14. 10. 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-300, 71 3859		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. [REDACTED]		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Leti, Phillip</i>		2. DATE AND HOUR OF DEATH <i>4-16-71 - 6:30 am</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Harbor View Nursing Center 1213 Light Street Baltimore, Maryland 21230</i>		C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i> 6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Laborer</i>		8. DATE OF BIRTH <i>4-12-86</i> 9. AGE (In years last birthday) <i>85</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>City Gov't.</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
13. FATHER'S NAME <i>unobtainable</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		14. MOTHER'S MARDEN NAME <i>unobtainable</i>	
16. SOCIAL SECURITY NO. <i>218-10-3875</i>		17. INFORMANT <i>Chart</i> ADDRESS	
18. <i>4-12-4 I</i> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i> <i>Weeks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Severe and Generalized ASCVD, Cardiovascular and Cerebral</i> <i>Years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) <i>Decubitus Ulcers</i> <i>Months</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPST? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notly medical exomined)		21B. PLACE OF INJURY (e.g., in or about home, farm, locorty, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>June 3</i> 19 <i>69</i> to <i>April 16</i> 19 <i>71</i> that (2) (we) last saw the deceased alive on <i>April 16</i> 19 <i>71</i> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Peter H. Rheinstein, M.D.</i>		23B. DATE SIGNED <i>April 17, 1971</i>	
23C. PHYSICIAN'S NAME (Type) <i>Peter H. Rheinstein, M.D.</i>		23D. ADDRESS <i>Harbor View Nursing Center Baltimore, Maryland 21230</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>19 Apr 71</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Most Holy Redemptor</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE RECD BY HEALTH DEPT. <i>APR 21 1971</i>		25B. NAME OF REGISTRAR <i>U.S. E. J. J. J.</i>	
25C. FUNERAL DIRECTOR <i>U.S. E. J. J. J.</i>		ADDRESS <i>U.S. E. J. J. J.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

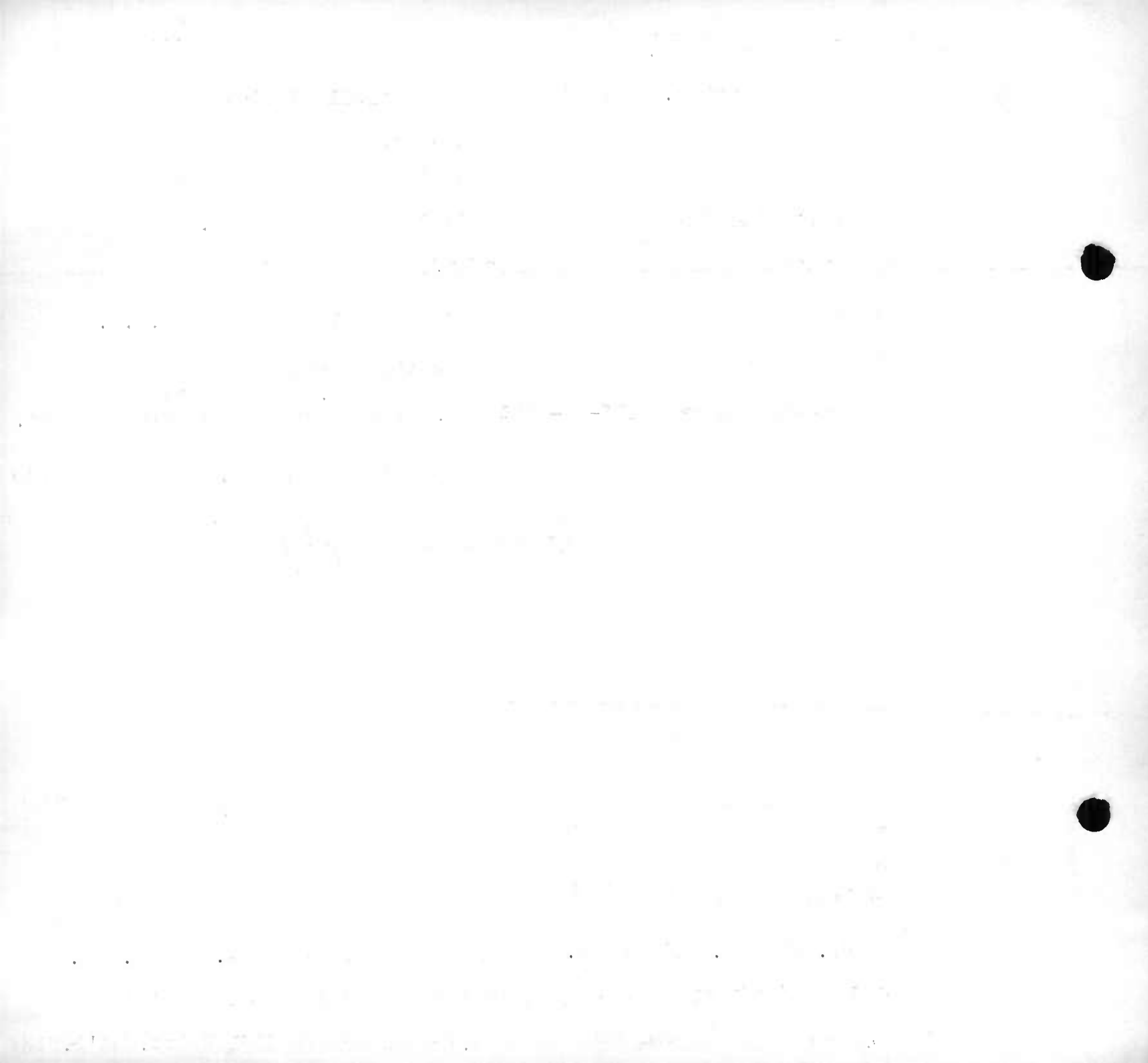
BALTIMORE CITY HEALTH DEPARTMENT				71 3860
71 3860 CERTIFICATE OF DEATH			REG. NO. _____	
1. NAME OF DECEASED (Type or Print) W. Carlton Markland			2. DATE AND HOUR OF DEATH April 17, 1971 8 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2755	
FULL NAME OF HOSPITAL OR INSTITUTION 90 The Wesley Home 2211 West Rogers Avenue			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2211 West Rogers Avenue				
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Jan 94	9. AGE (in years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10B. KIND OF BUSINESS OR INDUSTRY Carpentry	
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Edward Markland			14. MOTHER'S MAIDEN NAME Ella Craver	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219 30 2663	
17. INFORMANT The Wesley Home same			ADDRESS	
18. 410.9 I CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) Anteroseptal Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C)				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3 November 1969 to 17 April 1971 that (I) (we) last saw the deceased alive on 30 March 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>John W. Barnaby</i> Dr. John W. Barnaby			23B. DATE SIGNED 20 Apr 71	
23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby			23D. ADDRESS 1652 E. Belvedere Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 19 Apr 71		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State) Woodlawn, Baltimore Co. Maryland				
25A. DATE REC'D BY HEALTH DEPT. ADD 21 1071		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Burgess Funeral Home, Baltimore, Maryland
25D. ADDRESS By: <i>Harold Brown Jr.</i>				

12/63 Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

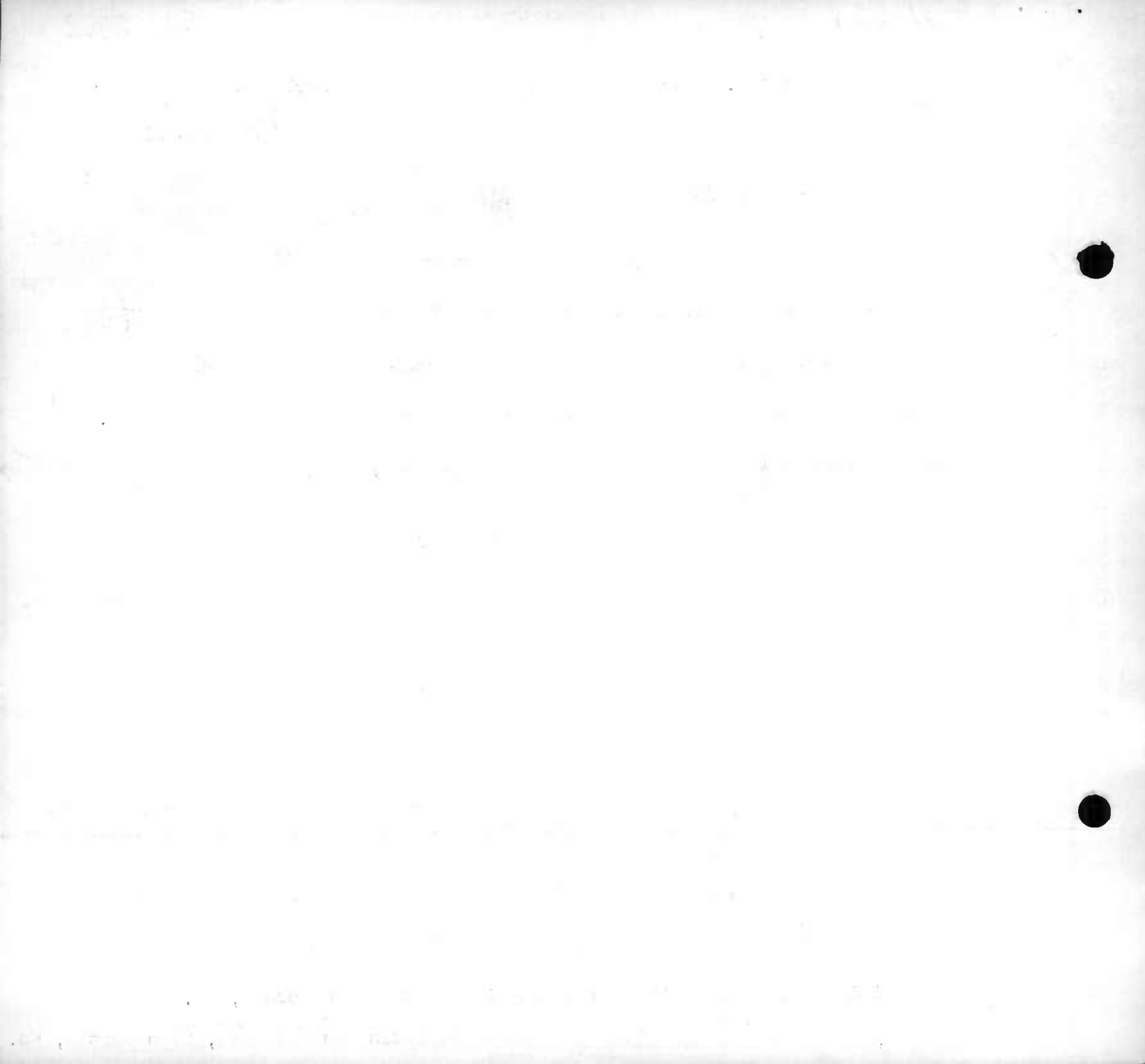
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3861	
S-330 71 3861 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Albert B. Suddueth		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH April 16 1971 11:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1433 Washington Blvd.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1909	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Warrenton, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Suddueth			
14. MOTHER'S MAIDEN NAME Bessie Kendle		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II			
16. SOCIAL SECURITY NO. 215-09-0141		17. INFORMANT W. 1433 Mrs. Jessie Suddueth Washington Blvd.			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE Cor. Pulmonale DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="width: 5%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 11 years </div> </div>					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 	
22. I certify that (I) (this hospital) attended the deceased from 1-22- 19 49 to 4-16 19 71 that (I) (we) last saw the deceased alive on 4-16 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr.				23B. DATE SIGNED 4/19/71	
23C. PHYSICIAN'S NAME (Type) Dr. John P. Urlock Jr.				23D. ADDRESS 1227 Washington Blvd. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/1971		24C. NAME of CEMETERY or CREMATORY Warrenton, Virginia	
24D. LOCATION (City, town, or county) (State) Warrenton, Virginia		25A. DATE REC'D BY HEALTH DEPT. APR 21 1971			
25B. NAME OF REGISTRAR R. E. F. M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. Nat'l. Pike			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3862	
U-320 71 3862		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Earl R. Watts		April 19, 1971 9:42 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
37 Mercy Hospital		Md Anne Arundel 5200			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Hanover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		109 Reavis Rd			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-28-01	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Book keeper		Arnold Office Supply Baltimore		12. CITIZEN OF WHAT COUNTRY?	
				USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Oliver Watts			Minnie ? (unknown)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No None		216/07/4324		Mary Ann Serra (daughter)	
				ADDRESS Darlington Md.	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/4/71 to 4/18/71 that (I) (we) last saw the deceased alive on 4/18/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Kwinn M.D. DEGREE				4/18/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
KYZ K Lwzn DEGREE				Mercy Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/22/71		Glen Haven Memorial Park	
				Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 21 1971		Robert E. Taylor, M.D.		4800 Lincoln	
				ADDRESS Singleton Funeral Home, Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

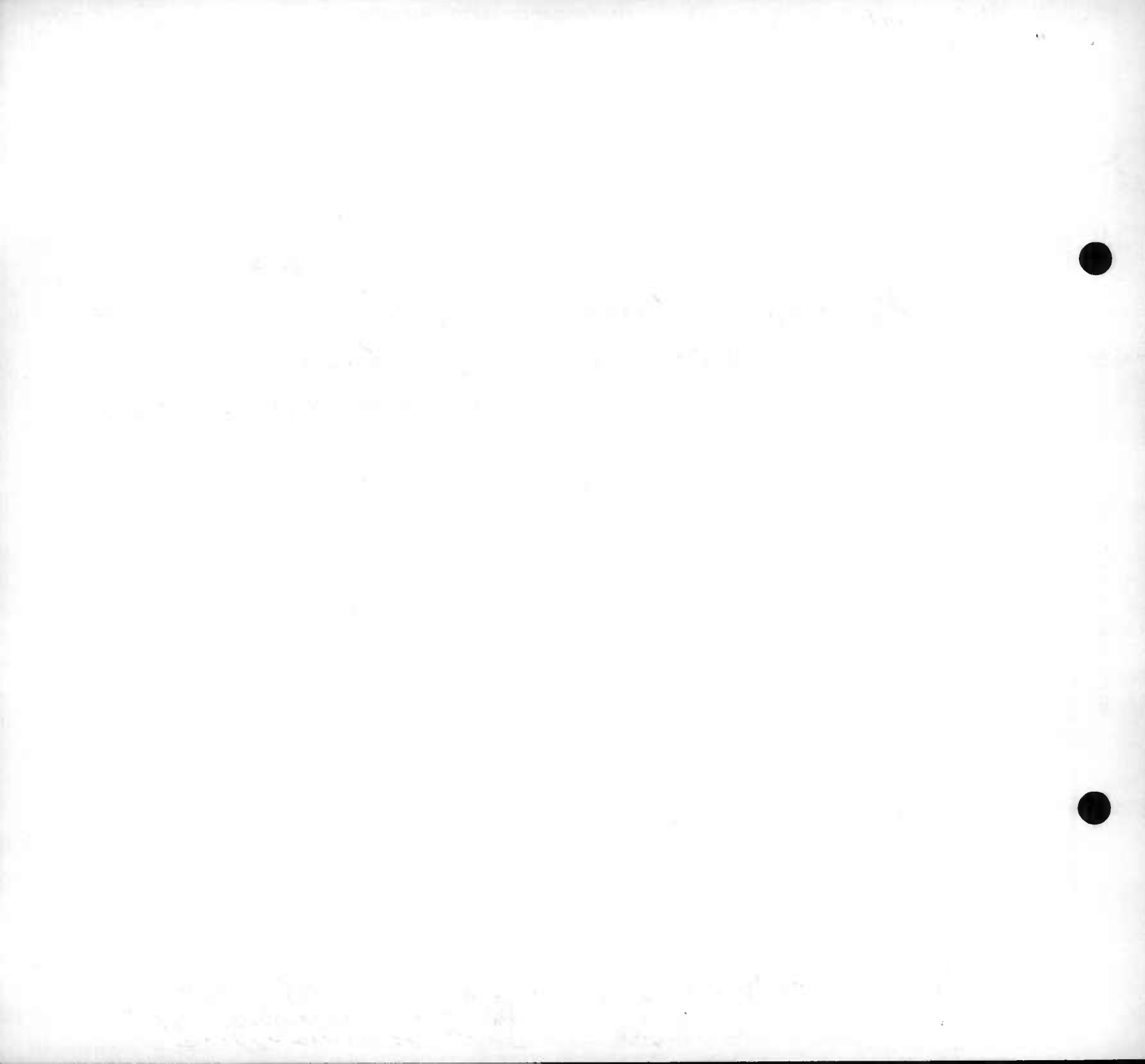
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-425 71 3863		BALTIMORE CITY HEALTH DEPARTMENT		71 3863	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) John Kilcoyne			2. DATE AND HOUR OF DEATH April 19, 1971 11 00 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3743 Elm Avenue Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3743 Elm Avenue 21211		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1912	9. AGE (In years last birthday) 58 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Singer sewing Mac.		11. BIRTHPLACE (State or foreign country) Clinton, Mass	
13. FATHER'S NAME Patrick Kilcoyne			12. CITIZEN OF WHAT COUNTRY? U.S.A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - - -			16. SOCIAL SECURITY NO. 069-05-7489		
17. INFORMANT Iris Kilcoyne-3743 Elm Ave. 21211			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/22/70		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-22 1970 to 4-19 1971 that (I) (we) last saw the deceased alive on 4-19 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reuben Hoffman, M.D.			23B. DATE SIGNED 4-19-71		
23C. PHYSICIAN'S NAME (Type) REUBEN HOFFMAN, M.D.			23D. ADDRESS 846 W. 36th St. Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/71		24C. NAME of CEMETERY or CREMATORY St. Johns Cemetery	
24D. LOCATION Lancaster, Mass.		25A. DATE REC'D BY HEALTH DEPT. APR 21 1971			
25B. NAME OF REGISTRAR Robert E. Kelley, R.D.		25C. FUNERAL DIRECTOR Donovan Funeral Home 3818 Roland Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

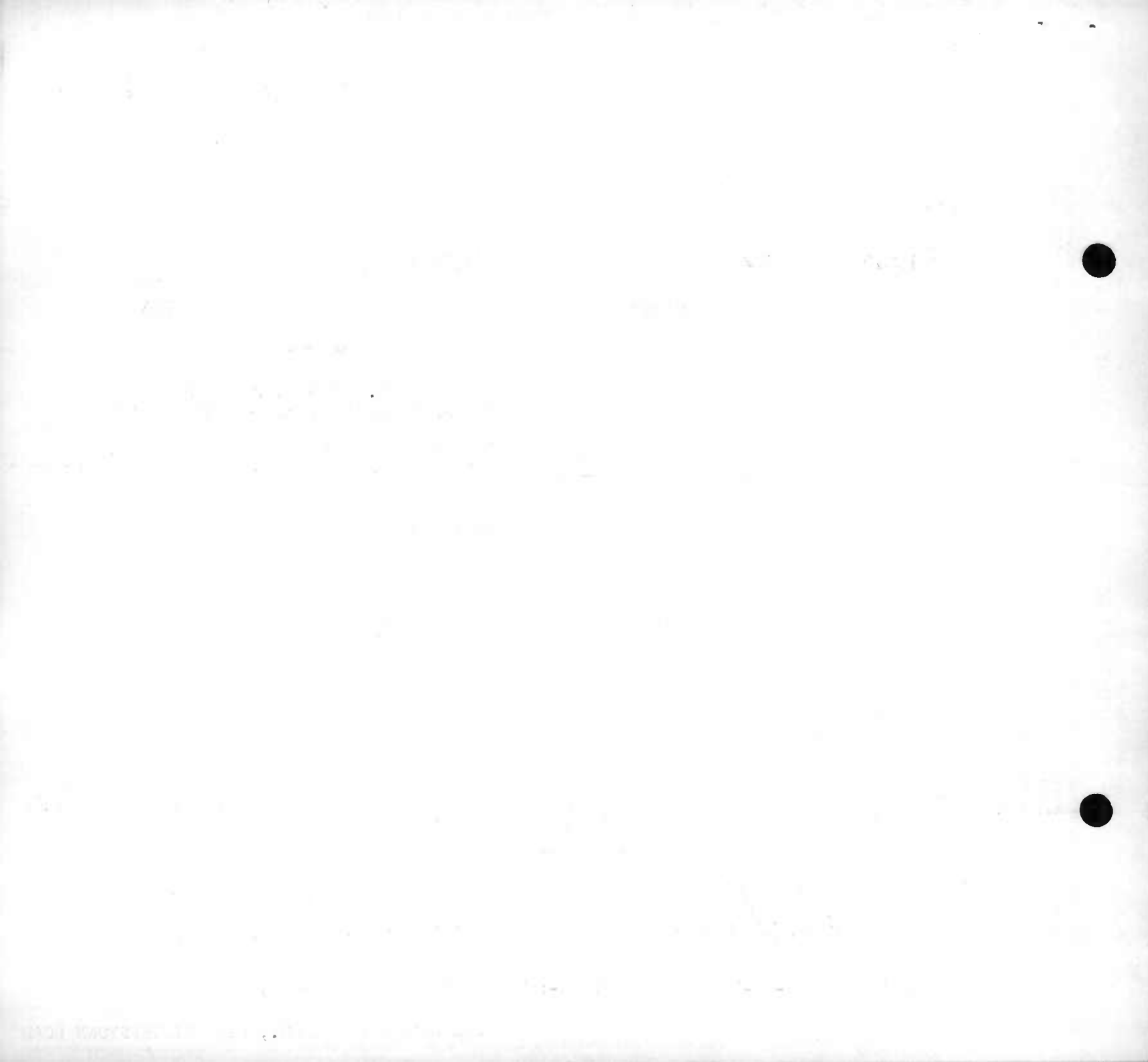
71 3864		BALTIMORE CITY HEALTH DEPARTMENT		71 3864	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Applebaum Anne</i>			2. DATE AND HOUR OF DEATH <i>4-17-71 9:00 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4251 n. Hospital of Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>21215</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>Maryland</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>70</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Mullstein</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mrs. Telle Lazarus - same</i>		
18. <i>41231</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Myocardial infarction due to chronic coronary artery disease; prior rupture of aorta, aortic aneurysm</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>4-17-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>4-14-71</i> 19 <i>71</i> to <i>4-17</i> 19 <i>71</i> that (1) (we) last saw the deceased alive on <i>4-17</i> 19 <i>71</i> and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodolfo S. Victoria MD</i>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>Rodolfo S. Victoria MD</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>4/18/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Potomac Park Cemetery</i>
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>			24E. STATE <i>MD</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>APR 21 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>John J. ...</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

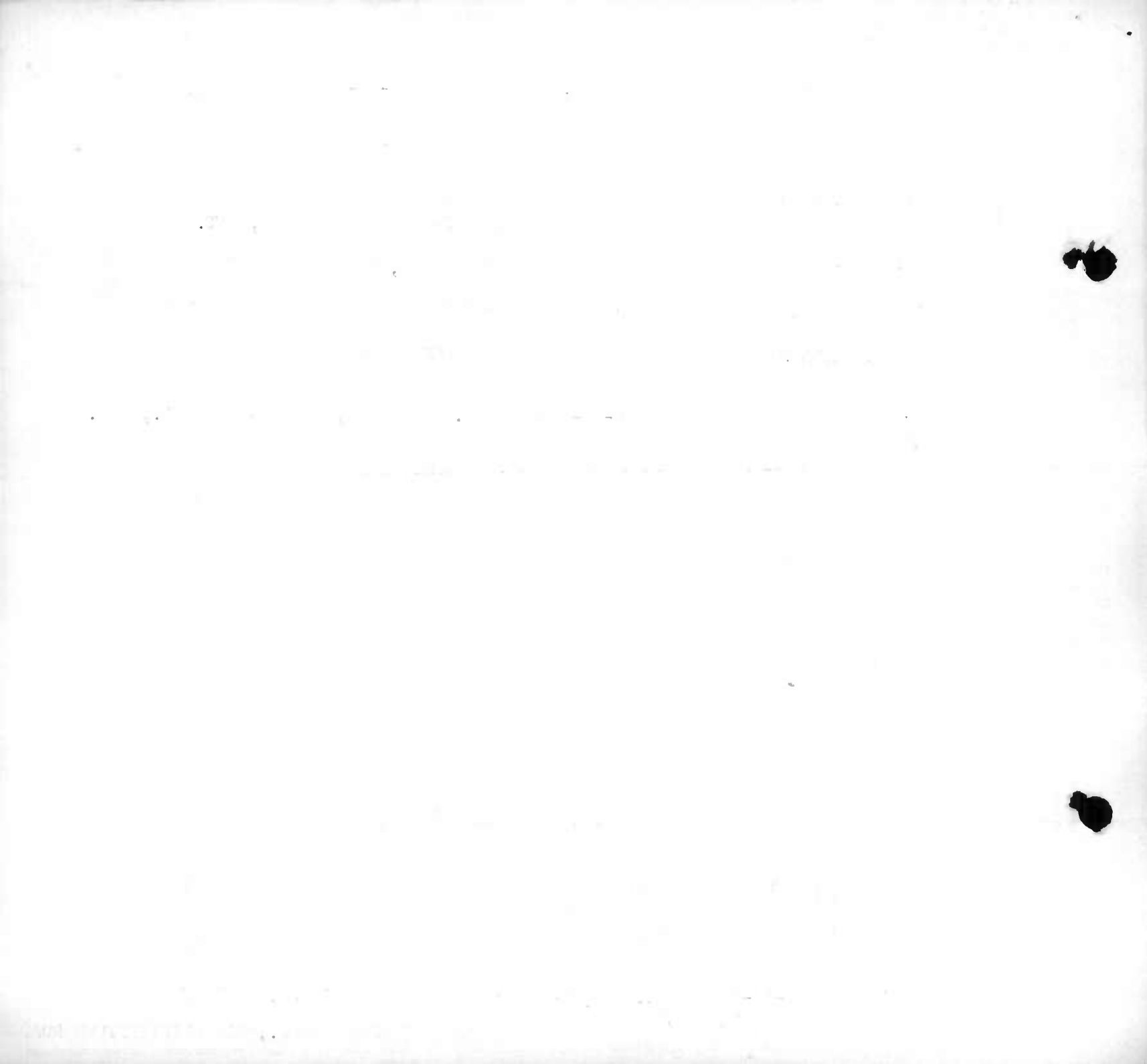
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3865</u>	
71 3865				CERTIFICATE OF DEATH	
BIRTH NO. <u>1-452</u>		1. NAME OF DECEASED (Type or Print) <u>Esther Dalnekoff</u>		2. DATE AND HOUR OF DEATH <u>4-17-71</u> <u>6:55a</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u> <u>49</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5308 Nelson Avenue</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXX</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Jack Labinsky</u>			14. MOTHER'S MAIDEN NAME <u>? UNKNOWN</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MR. SAMUEL DALNEKOFF</u> <u>XXXXXXXX 5308 NELSON AVENUE</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CORONARY ARTERIOSCLEROSIS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CORONARY ARTERIOSCLEROSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ARTERIOSCLEROSIS</u> <u>CONGESTIVE CARDIAC FAILURE</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>4-26</u> 19 <u>71</u> to <u>4-17</u> 19 <u>71</u> . that (I) <u>we</u> last saw the deceased alive on <u>4-17</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frank Gross</u>				23B. DATE SIGNED <u>4-17-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK GROSS</u>				23D. ADDRESS <u>10372 Fawcett, Columbia, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-18-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>MIKRO KODESH-BETH ISRAEL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Gross, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3866	
BIRTH NO. 8-152 71 3866				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RUBINSTEIN, Louis			2. DATE AND HOUR OF DEATH 4-15-71 9:35 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 12 SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1730		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3001 ROMARIC COURT, APT. G		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 15, 1885	9. AGE (in years last birthday) 85	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JACK RUBINSTEIN		
14. MOTHER'S MAIDEN NAME ROSE ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 220-22-7876			17. INFORMANT ADDRESS MRS. ROSE BLUM, 3001 ROMARIC CT., APT. G		
18. CAUSE OF DEATH 4-10-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? Myocardial infarction A-U. dissection (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15/71 to 4/15/71 that (I) (we) last saw the deceased alive on 4/15/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ali M. Safa			23B. DATE SIGNED 4/15/71		23C. PHYSICIAN'S NAME (Type) ALI M. SAFA, M.D.
23D. ADDRESS Sinai Hosp. of Balt.			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 4-18-71		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Kelly, R.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



100-15

100-15

100-15

ACADEMY

CONFIDENTIAL

100-15

100-15

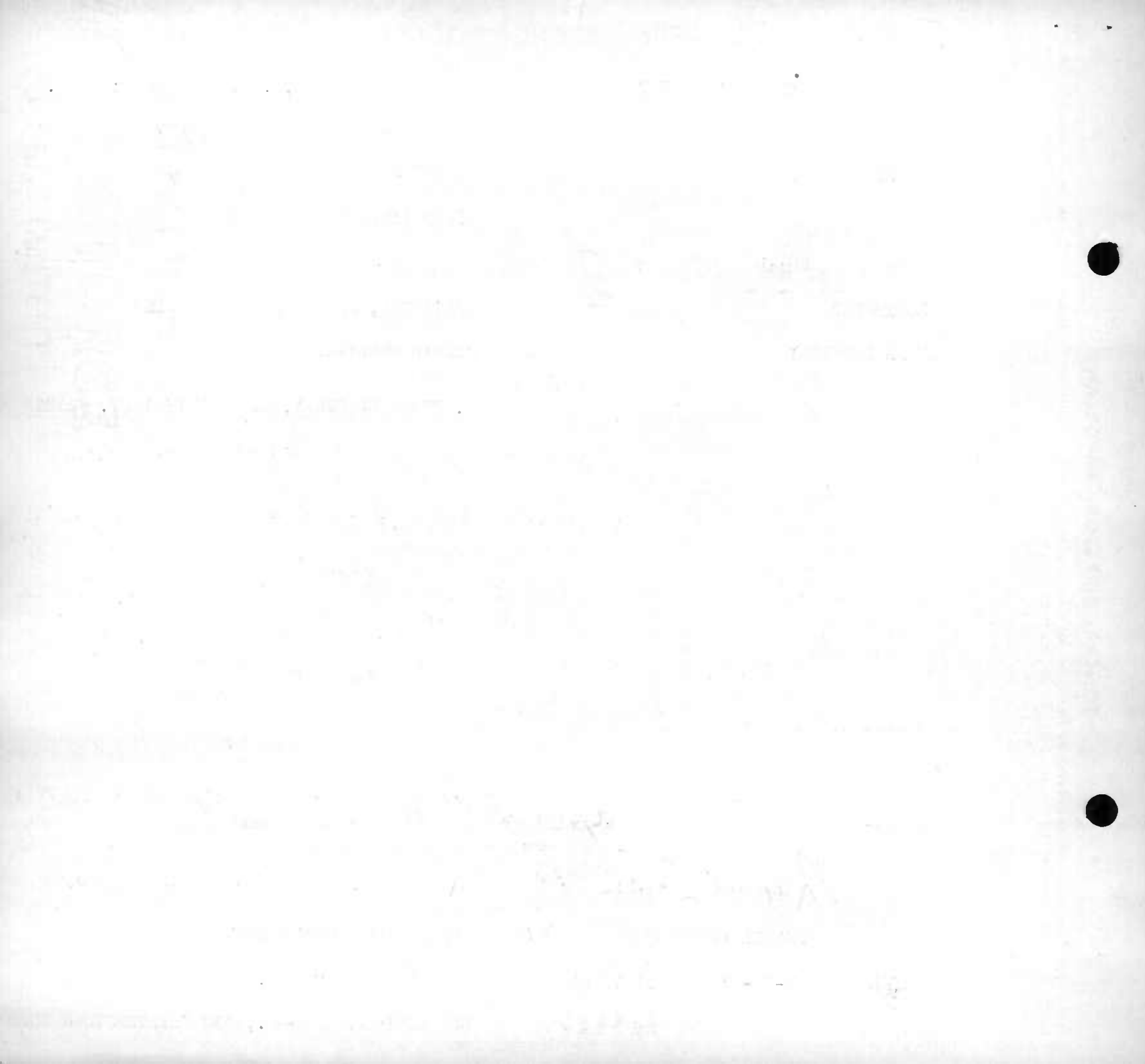
100-15

100-15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3868
BIRTH NO. 7-612 71 3868		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ISRAEL ZEROFSKY		2. DATE AND HOUR OF DEATH APRIL 16, 1971 6:55 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 2798 C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5009 LITCHFIELD AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 63	9. AGE (In years last birthday) 63 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKEEPER		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HYMAN ZEROFSKY		
14. MOTHER'S MAIDEN NAME JENNIE MERETZKY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. MR. FRANK ZEROFSKY, 2524 ST PAUL ST. #21218		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction 410.9 I		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease 7 years		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: None (C) DUE TO, OR AS A CONSEQUENCE OF: None		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Sept 3 1961 to April 16 1971 that (I) (we) last saw the deceased alive on April 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Manuel Levin M.D.		23B. DATE SIGNED 4/16/71		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN
23D. ADDRESS 6101 PARK HEIGHTS AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 4-18-71		24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



A-142

71 3869

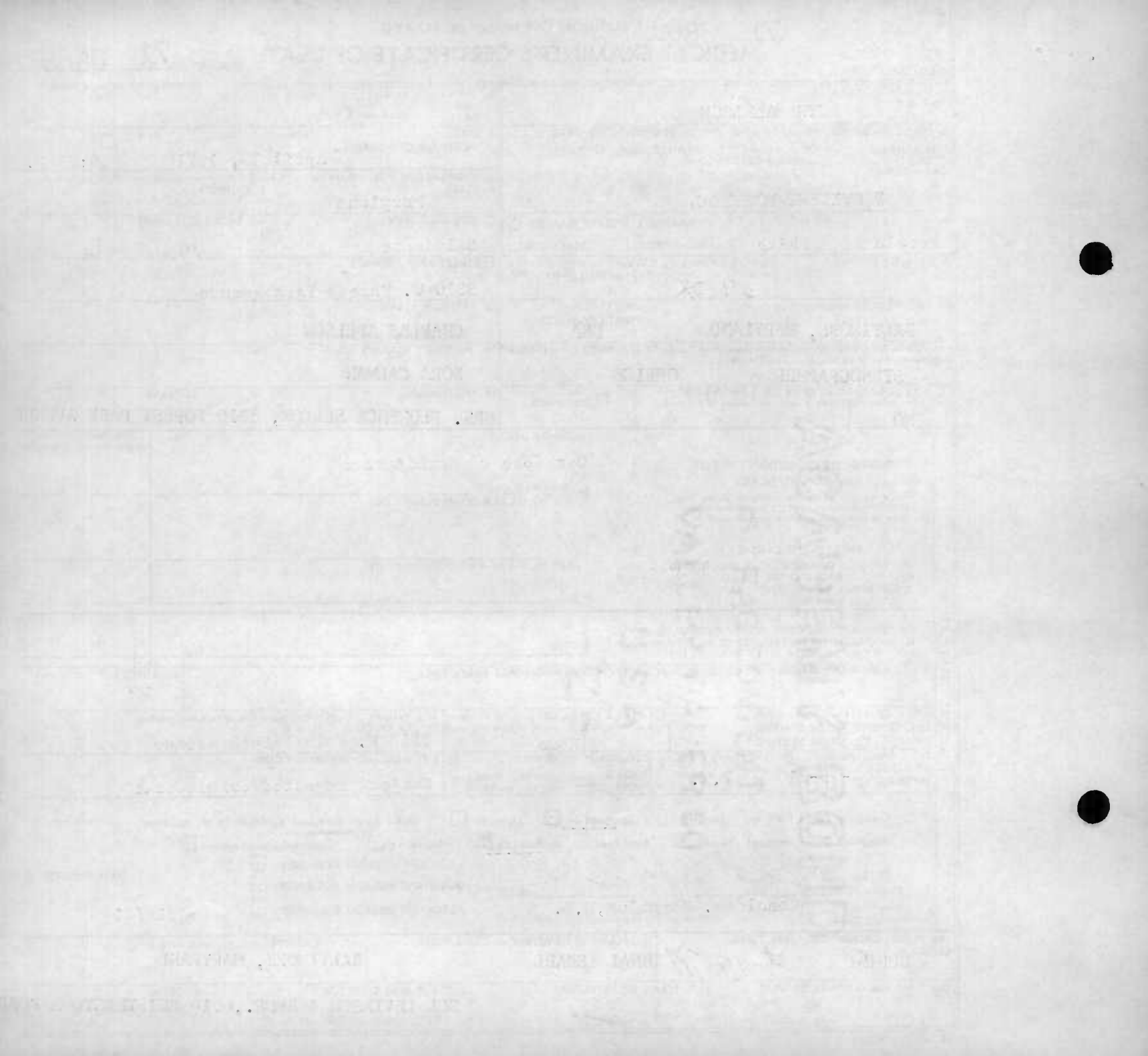
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3869

BIRTH NO.

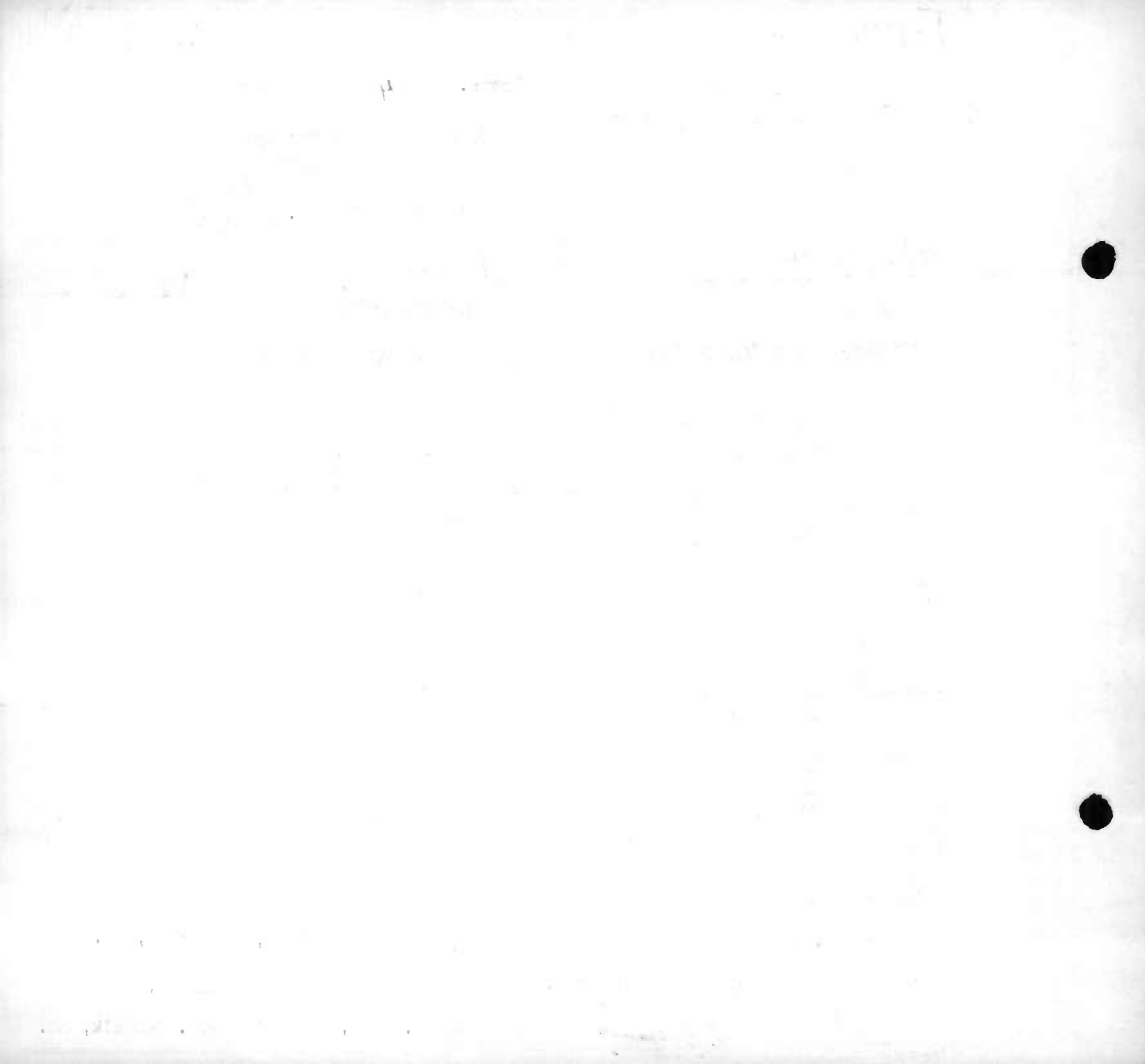
1. NAME OF DECEASED (Type or Print) RUTH ABELSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1971 10:23 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1538	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 59		E. STREET AND NUMBER 3310 W. Forest Park Avenue	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHER		14B. KIND OF BUSINESS OR INDUSTRY OFFICE	
15. MOTHER'S MAIDEN NAME DORA CALMAN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS MRS. FLORENCE SELKOW, 3310 FOREST PARK AVENUE	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E950.10 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Overdose of Barbiturate (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION O		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3310 W. Forest Park Avenue 1538		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-15-71 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject ingested barbiturate	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 4/16/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-17-71	
24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. 21 1971		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

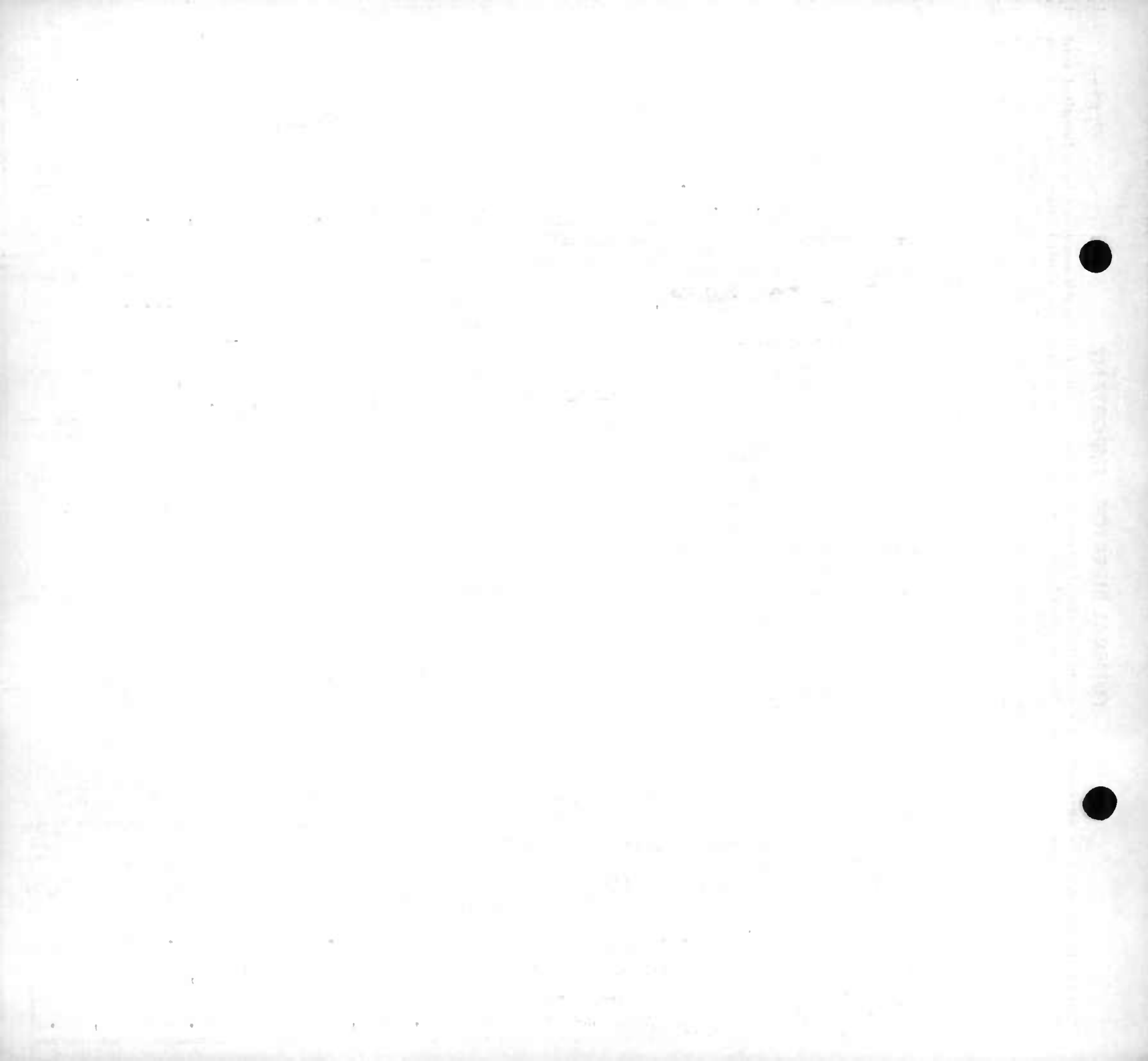
T-460 71 3870		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 3870	
1. NAME OF DECEASED (Type or Print) TAYLOR BABY BOY Charles R. Taylor				2. DATE AND HOUR OF DEATH 4/18/71 9:55AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Church Home & Hospital FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Church Home and Hospital 700 N Broadway Street Balt. MD 21231				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore			
5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4/17/71		9. AGE (in years last birthday) 13 10. Under 1 Yr. Months 13 11. Under 24 Hrs. Days 12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME TAYLOR, CHARLES W.			
14. MOTHER'S MAIDEN NAME SIMPSON, FRANCIS				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT A. Fayed None Church Home Hosp			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Extensive Pulmonary embolism and aspiration pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia and Respiratory Distress Syndrome (C) DUE TO, OR AS A CONSEQUENCE OF: Prematurity OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hrs.			
19A. DATE OF OPERATION None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> None			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from 8:43 PM 4/17, 1971 to 9:55 AM 4/18, 1971 that (I) (we) last saw the deceased alive on 4/18, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George H. Wall				23B. DATE SIGNED 4/18/71		23C. PHYSICIAN'S NAME (Type) George H. Wall	
23D. ADDRESS Church Home & Hospital, Baltimore, Md.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4/20/71				24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971				25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave., Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-530</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3871</u>	
1. NAME OF DECEASED (Type or Print) <u>Edgar Hunt</u>			2. DATE AND HOUR OF DEATH <u>Apr 17, 1971</u> <u>7</u> <u>55</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Dundalk</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>11-5-09</u>			9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dock Worker-Esskays Meat Co.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Clayton Hunt</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Jacobs</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>241-16-8976</u>			17. INFORMANT <u>4940 Eastern Ave,</u> <u>BCH Records: Baltimore, Md. 21224</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <u>4/16</u> 19 <u>71</u> to <u>4/17</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James Corkins MD</u>			23B. DATE SIGNED <u>Apr 17, 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>James Corkins M.D.</u>			23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/21/71</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>			24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>			25B. NAME OF REGISTRAR <u>John E. Faby, M.D.</u>		
25C. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>			ADDRESS		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 3872</u>	
C-656		71 3872		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Leona G. Cramer		April 19, 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> Baltimore City Hospital				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> <u>5300</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Fort Howard</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Todd & Oak Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-27</u>	9. AGE (in years lost birthday) <u>43</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert P. Cramer</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Hardesty</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-24-9480</u>		17. INFORMANT <u>Husband:</u> <u>Box 215</u> ADDRESS <u>Mr. Burlin D. Cramer</u> <u>Ft. Howard, Md. 21052</u>			
18. <u>4/10/71</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> <u>1962</u> to <u>4-18</u> <u>1971</u> that (I) (we) lost saw the deceased alive on <u>4-18</u> <u>1971</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John V. Conway, M.D.</u>				23B. DATE SIGNED <u>4-20-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>John V. Conway, M.D.</u>				23D. ADDRESS <u>914 D Street</u> <u>Sparrows Point, Md. 21219</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-22-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Preston Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Preston Co. West Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>			



P 630

71 3873

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3873

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND PERDUE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 6, 1971 12:40 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1102			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH April 30, 1918	10. AGE (in years last birthday) 53 ?	E. STREET AND NUMBER 517 Cathedral Street	
11. BIRTHPLACE (State or foreign country) Yards, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Perdue		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Pearl Perdue		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes ARMP	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. M. Davis Box 227B Rt. 2 Ft. Royal, Va. 22630	
19. CAUSE OF DEATH 5-71-91		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cirrhosis of liver	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/7/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/22/71	24C. NAME OF CEMETERY OR CREMATORY Calpepper Nat'l Cem.	24D. LOCATION (City, town, or county) (State) Calpepper, Va.
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS Sho. L. Schwab, Inc.	

MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
TO: [Illegible]
FROM: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report with several paragraphs of text, possibly including a list or table. Some words like "The following", "It is", and "The" are faintly visible.]

1
8525

71 3874

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3874

BIRTH NO.		2. DATE OF DEATH	
1. NAME OF DECEASED (Type or Print) EARL JOHNSON		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1351 Whatcoat Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 17, 1971 8:30 P.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE Maryland B. COUNTY 1501	
7. RACE Negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 8/3/1925		E. STREET AND NUMBER 1351 Whatcoat Street	
10. AGE (In years lost birthday) 45		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leon Johnson Sr.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Mary Beckett	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO.	
18. INFORMANT Leon Johnson, 4022 Green Spring Ave.		ADDRESS	
19. E 9661 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stab wound of chest		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1351 Whatcoat Street 1501		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 4-17-71 8:15 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/18/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/71	
24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kenneth H. Law		ADDRESS 4611 Park Heights Ave.	

1000

11/1/71

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

JAMES ALLEN WILSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 LUTHERAN HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 17, 1971

7:55 P.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

1501

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Nov. 3, 1951

10. AGE (In years
last birthday)

19

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1708 N. Calhoun Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

James M. Wilson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marjorie Coles

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

217-56-7127

18. INFORMANT

ADDRESS

Marjorie Wilson, 1708 N. Calhoun St.

19.

E 965 X

CAUSE OF DEATH

Gunshot wound of chest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Store

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2901 Clifton Avenue 1506

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY
(APPROX.) 4-17-71

7:45 P.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot while robbing store

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/22/71

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland 2

25A. DATE REC'D BY HEALTH DEPT.

APR 21 1971

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Kenneth H. Law, 4611 Park Heights Ave.

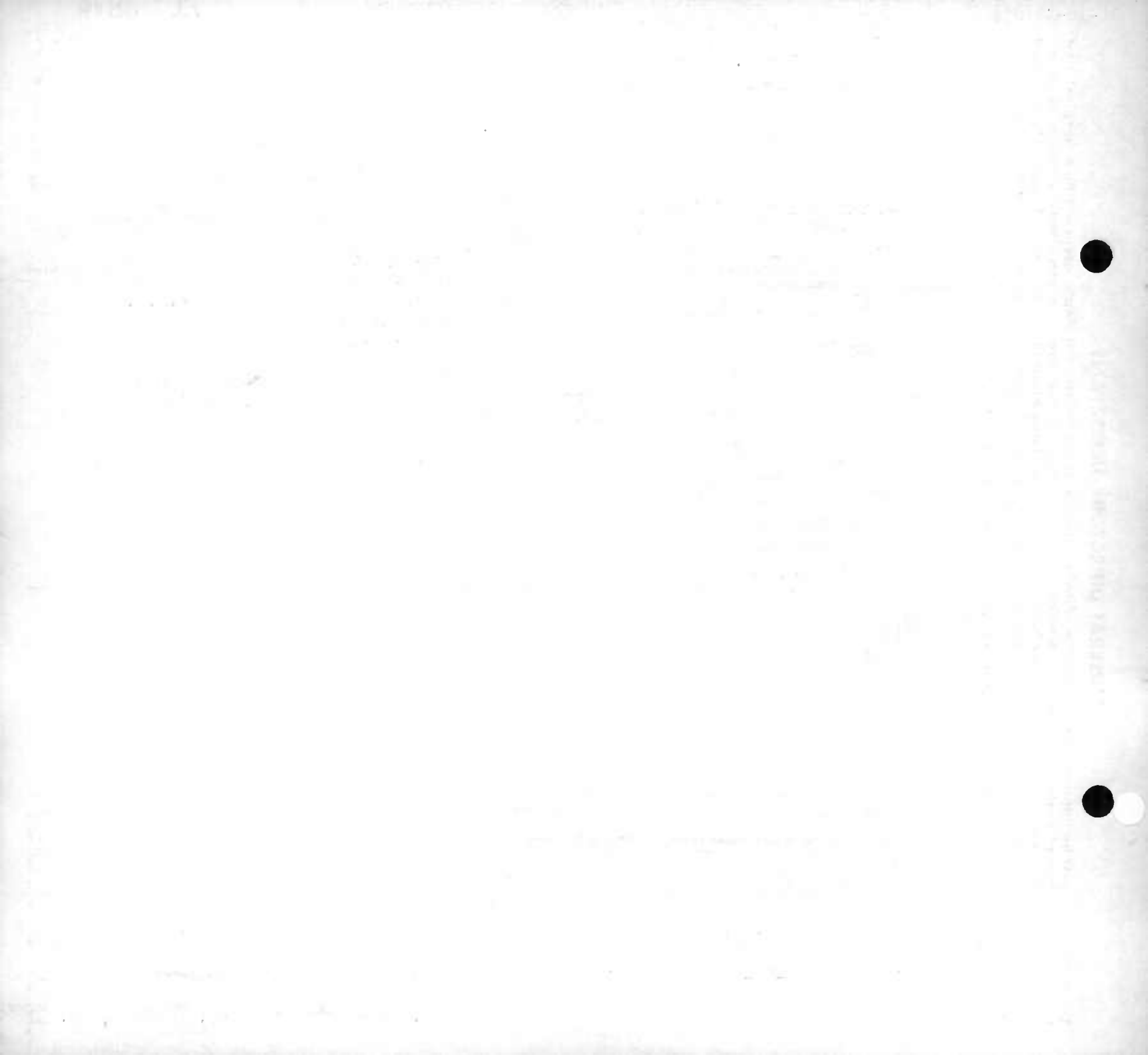
MEDICAL EXAMINER'S REPORT OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Physical Examination		Mental Examination	
Laboratory Examinations		X-ray Examinations		Other Examinations	
Signatures of Medical Examiner		Signatures of Witnesses		Signatures of Coroner	
Date of Report		Time of Report		Place of Report	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

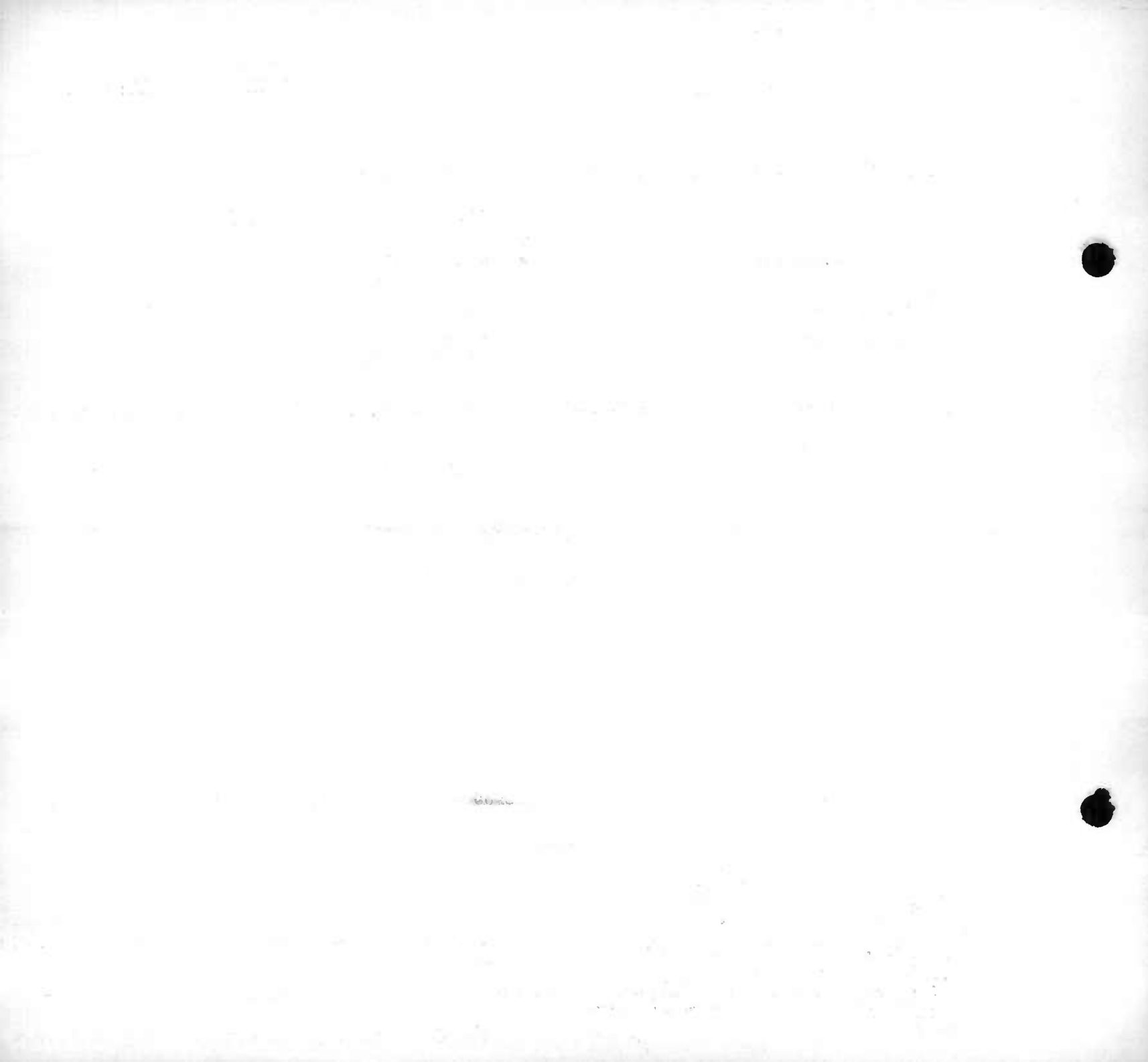
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3876	
BIRTH NO. 71 3876		71 3876			
1. NAME OF DECEASED (Type or Print) <u>Elma F. Rexrode</u>			2. DATE AND HOUR OF DEATH <u>4/14/71</u> 8 ³⁰ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>3 Baltimore City Hospitals</u>			A. STATE <u>Maryland</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>21224</u>			B. COUNTY <u>2636</u>		
<u>4940 Eastern Avenue Baltimore, Maryland</u>			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <u>12/26/08</u>			9. AGE (in years) (last birthday) <u>62</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Boyd Rexrode</u>		
14. MOTHER'S MAIDEN NAME <u>Maggie Hinkle</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>BCH: Records</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>		
18. <u>4/23/71</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE <u>Heart Failure</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			DUE TO, OR AS A CONSEQUENCE OF: <u>ASH D.</u>		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>possible pulmonary emboli</u> <u>G.F. bleeding</u>		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 6</u> 19 <u>71</u> to <u>Feb 14</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Feb 14, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Allan Krumholz M.D.</u> DEGREE			23B. DATE SIGNED <u>4/14/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Allan Krumholz, M.D.</u> DEGREE			23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-17-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bel Air Memorial Gardens</u>	
24D. LOCATION (City, town, or county) (State) <u>Bel Air Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21224</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3877</u>	
<div style="display: flex; justify-content: space-between;"> <u>S-552</u> <u>71</u> <u>3877</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>John Julius Simmons</u>			2. DATE AND HOUR OF DEATH <u>April 19, 1971</u> <u>12:55 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Virginia</u> B. COUNTY <u>V-43</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>U.S. Public Health Service Hospital</u>			C. CITY OR TOWN <u>Falls Church</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Engineer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Seaman</u>		8. DATE OF BIRTH <u>Mar. 8, 1922</u>
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>			9. AGE (in years last birthday) <u>49</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Bernard Simmons</u>			14. MOTHER'S MAIDEN NAME <u>Sally Hadley</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>1940-1941</u>			16. SOCIAL SECURITY NO. <u>417-22-0196</u>		17. INFORMANT <u>Records-U.S. Public Health Service Hospital</u>
18. <u>130X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Viral pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>(B) Carcinoma of Larynx</u> <u>(C) Carcinoma of Esophagus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>wks</u> <u>1 yr</u> <u>1 yr</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>February 14</u> 19 <u>71</u> to <u>April 19</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>April 19</u> 19 <u>71</u> and that (our) opinion death occurred on the date and hour end from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles I. Wasserman M.D.</u>				23B. DATE SIGNED <u>April 19, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles I. Wasserman, M.D.</u>				23D. ADDRESS <u>U.S. Public Health Service Hospital, Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-23-71</u>		24C. NAME of CEMETERY or CREMATORY <u>WYNN CEMETARY</u>	
24D. LOCATION (City, town, or county) <u>Summerdale</u>		24E. STATE <u>ALa.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Inc.</u>		25D. ADDRESS <u>Towson, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3878	
<div style="display: flex; justify-content: space-between;"> P-625 71 3878 </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) PERKINS, BERNICE R. COOPER (ROWE) </div> <div> 2. DATE AND HOUR OF DEATH April 19, 1971 4 P.M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE GOOD SAMARITAN HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 BALTIMORE, MARYLAND 21239			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21217 804 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1214 Eutaw Pl., Key Circle Hospice		
5. SEX Female	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/19	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Cooper			14. MOTHER'S MAIDEN NAME Estella Pack		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 224251054		17. INFORMANT Mrs. Alma Martin 829 McLeer Court ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive arteriosclerotic cardiovascular vascular disease failure CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) CARDIAC CIRRHOSIS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			yes.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. A. over M.D.				23B. DATE SIGNED 4/19/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/22/71		Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR Wm C March 928 E. North Ave.			
24F. DATE RECEIVED BY HEALTH DEPT.		24G. NAME OF REGISTRAR		24H. ADDRESS	
APR 21 1971		John E. Feltz, Jr.		Wm C March 928 E. North Ave.	

1/11/71 Adm

2244 Murd. 57.

BALTIMORE CITY HEALTH DEPARTMENT				71 3879			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. _____			
BIRTH NO. _____							
1. NAME OF DECEASED (Type or Print) Gloria Taylor				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 19 71 5:45 p M.			
6. SEX female				7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-5-48				10. AGE (In years last birthday) 22		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Willie J. Canady		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Amanda Wolfolk				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
17. SOCIAL SECURITY NO.				18. INFORMANT Mrs. Amanda Jenkins 2056 Kennedy Ave.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 1533 Homestead St. 907				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4 19 71 5:25 p m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? shot during altercation			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 4/20/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/24/71			
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery				24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971 Robert E. Taylor, M.D.				25B. NAME OF REGISTRAR			
25C. FUNERAL DIRECTOR Wm C March				25D. ADDRESS 928 E. North Ave.			

ACADEMY BOND

THE CONTINGENT

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

OF THE ACADEMY

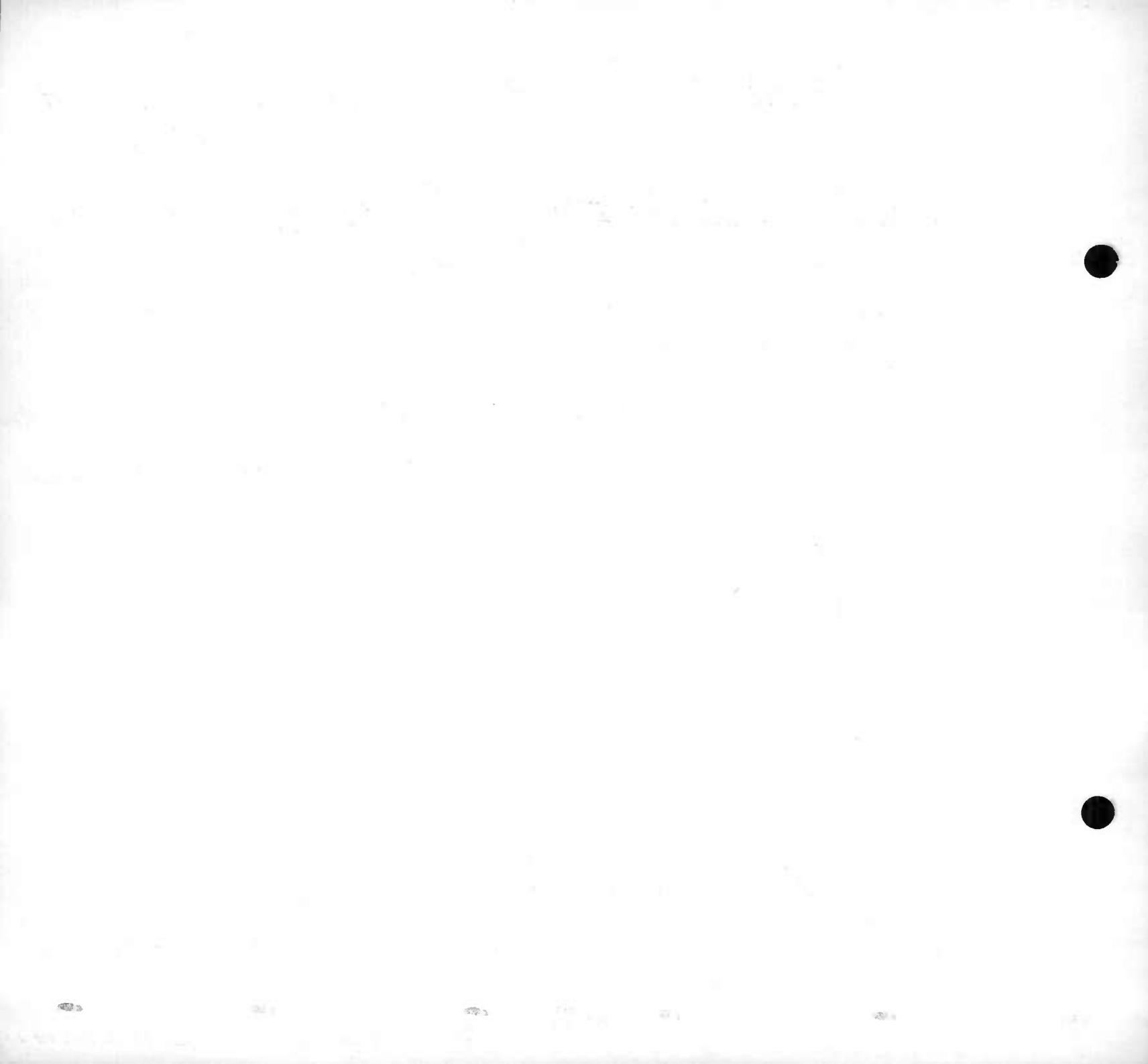
OF THE ACADEMY

OF THE ACADEMY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

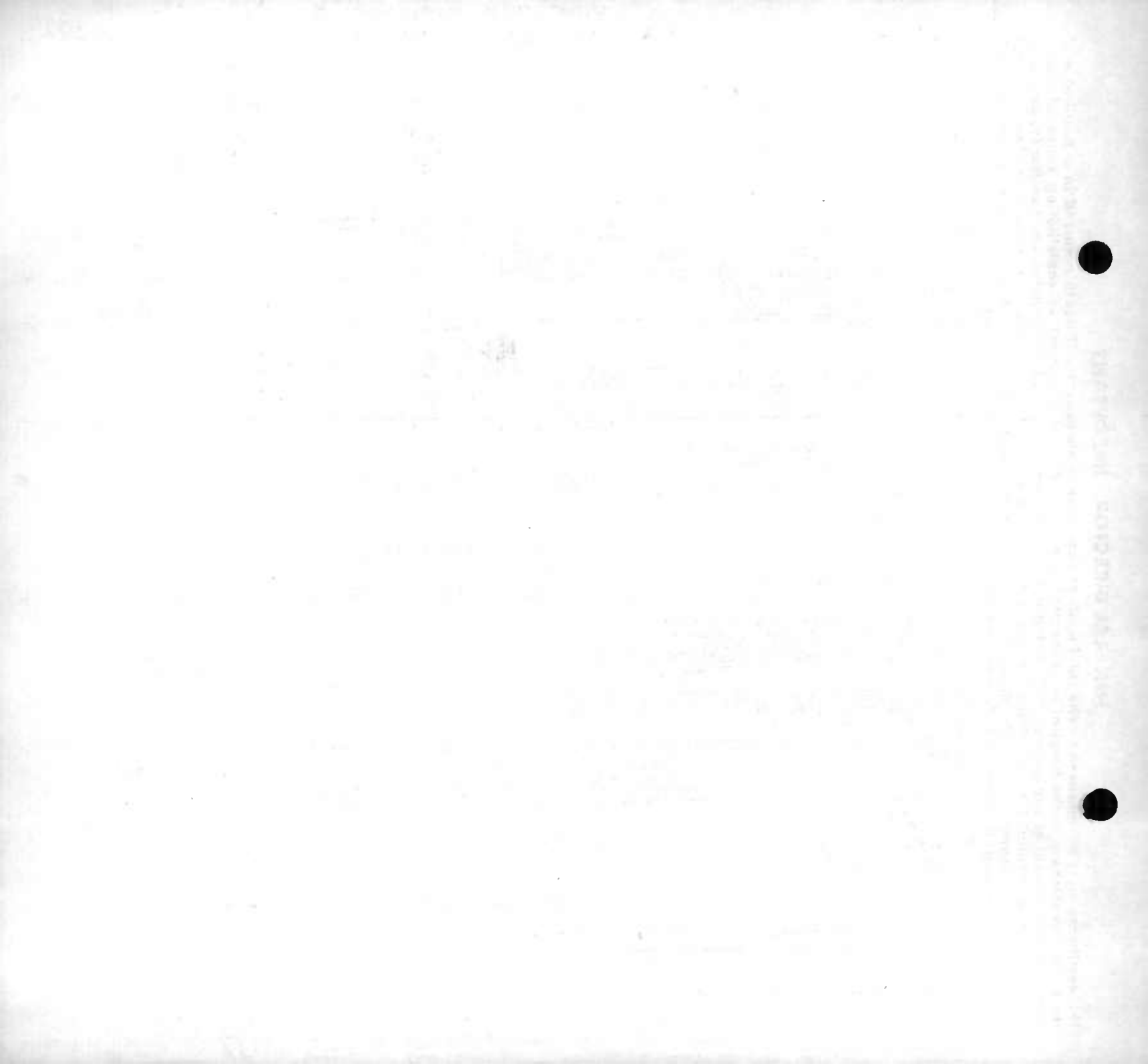
B-520 71 3880		BALTIMORE CITY HEALTH DEPARTMENT		71 3880	
BIRTH NO.		REG. NO.		71 3880	
1. NAME OF DECEASED (Type or Print) BARRY S. BANKS		2. DATE AND HOUR OF DEATH 4/20/71 4:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MONTGOMERY STATE HOSPITAL		A. STATE BALTIMORE		B. COUNTY CITY, MD.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1900 HILLENWOOD RD			
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/23/50	9. AGE (In years last birthday) 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY LABORER		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME DELAWARE BANKS		14. MOTHER'S MAIDEN NAME MARY L. WRIGHT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 214-56-5085		17. INFORMANT MRS M. BANKS	
				ADDRESS 1900 HILLENWOOD RD.	
18. 200.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RETICULOM CELL SARCOMA, BRAIN		1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION OCT or NOV 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RETICULOM CELL CARCINOMA, BRAIN		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/22/71 19 71 to 4/20 19 71 that (2) (we) last saw the deceased alive on 4/20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Kenneth Marshall, MD.				23B. DATE SIGNED 4/20/71	
23C. PHYSICIAN'S NAME (Type) JOSEPH KENNETH MARSHALL, MD.				23D. ADDRESS UNIVERSITY HOSPITAL BALTO MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/23/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. APR 21 1971		24F. NAME OF REGISTRAR WM C MARCH	
24G. ADDRESS 928 E NORTH AVE		24H. FUNERAL DIRECTOR		24I. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

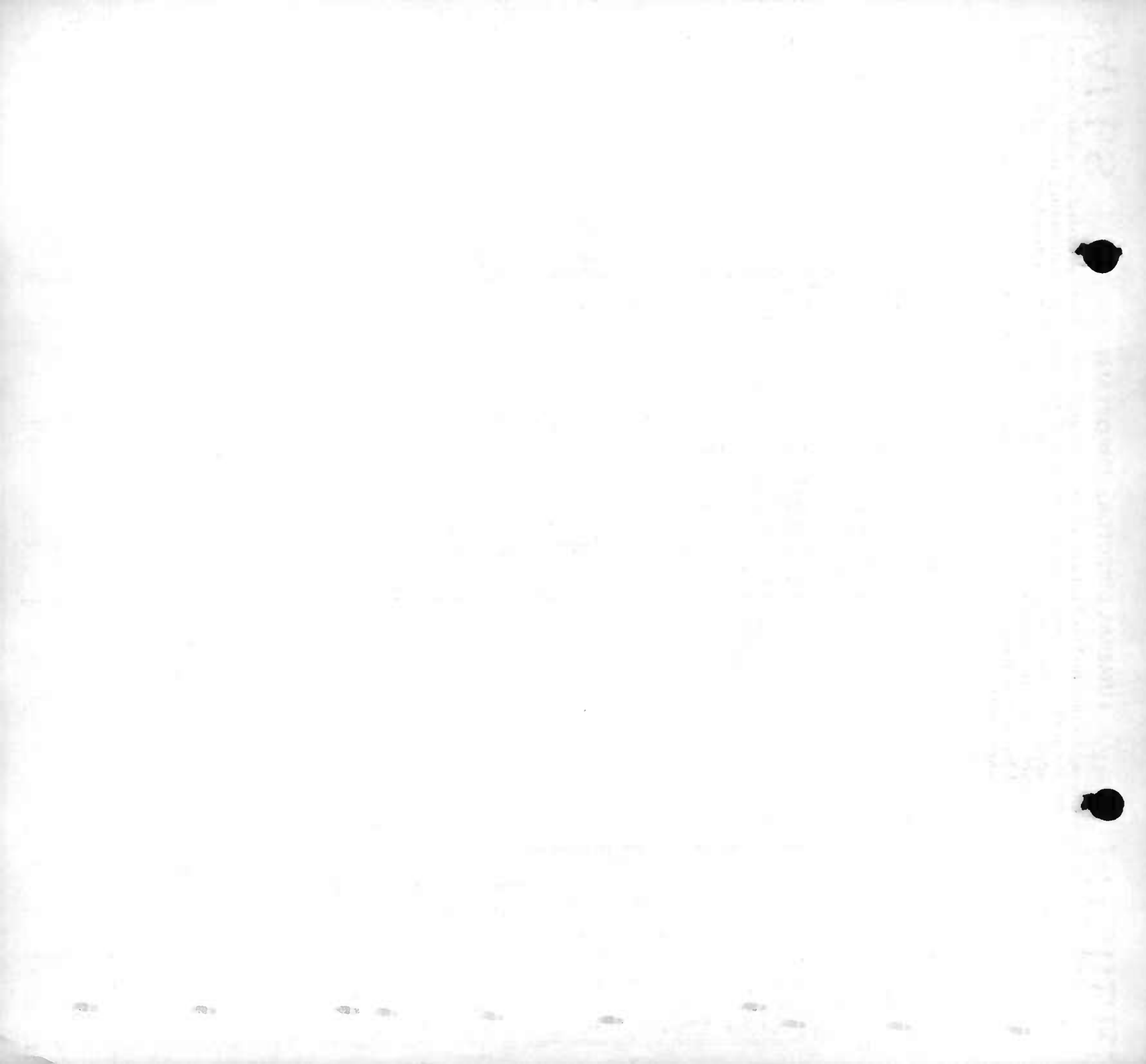
Baltimore City Health Department				71 3881		REG. NO. 71 3881	
S-530 BIRTH NO.				71 3881			
1. NAME OF DECEASED (Type or Print)				SMITH, Donnie		2. DATE AND HOUR OF DEATH 4-20-71 3:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY 808	
33 The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1027 Rutland Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/05/14	9. AGE (in years last birthday) 57	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel mill		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Polley Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 214-14-1714		17. INFORMANT Esther Smith		ADDRESS	
18. 44101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diverging Aortic Aneurysm 4-14 (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension yrs (C) Terminal Renal Disease ~ 4-10		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) XXXX NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4-10 19 71 to 4-20 19 71 that (1) (we) last saw the deceased alive on 38 4-20 19 71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Anthony S. Jennings MD				23B. DATE SIGNED 4-20		23C. PHYSICIAN'S NAME (Type) Anthony Jennings, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-23-71		24C. NAME of CEMETERY or CREMATORY Abnathus Cent		24D. LOCATION (City, town, or county) (State) White Mt	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR CONLOR 1000 Brambley Dr			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3882	
BIRTH NO. S-163 71 3882		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JUNIUS A. SHEPPARD		2. DATE AND HOUR OF DEATH 4-19-71 11 55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. - B. COUNTY 908 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 524 E. 23RD. ST.			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 27, 1900	9. AGE (in years last birthday) 70	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME ANDERSON SHEPPARD		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service ? -		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MEDICAL RECORD	
18. 4-12-71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 YEARS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PROBABLE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF:		3-4 days	
		(C) CHRONIC BLA- SYNDROME		9 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). EPILEPSY				8 yrs.	
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, fam., factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 4-15 1971 to 4-19 1971 that (I) (we) last saw the deceased alive on 4-19 1971 and that (in my) (last) apintan death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Lester A. Reid, M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-20-71	
23C. PHYSICIAN'S NAME (Type) LESTER A. REID, M.D. DEGREE		23D. ADDRESS UNION MEMORIAL HOSPITAL.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore		24E. STATE md.			
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR E.O. Wilson	
25D. ADDRESS 1000 Brantley Ave.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3883

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)~~John Willis Lionel Langford~~

John W. Langford

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

OR INSTITUTION

00 3911 Hayward Ave.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

8:35 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☐NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

1/11/82

10. AGE (In years lost birthday)

79

If Under 1 Yr. If Under 24 Hrs.

Months, Days, Hours, Min.

E. STREET AND NUMBER

3911 Hayward Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George W. Langford

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

clerk

14B. KIND OF BUSINESS OR INDUSTRY

Insurance Co.

15. MOTHER'S MAIDEN NAME

Margaret Albright

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No Yes

W. W. 1

17. SOCIAL SECURITY NO.

212 07 0439

18. INFORMANT

Roland E. Langford

ADDRESS

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/17/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4, 20, 71

24C. NAME OF CEMETERY or CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 21 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Edward S. MacNabb, Jr.

ADDRESS

John White Leland Langford

John A. Langford

Langford

Langford

X

Langford

Langford

George H. Langford

Langford

Margaret Albright

Insurance Co.

Clerk

215 07 0432 Roland H. Langford

W. W. I. No. 1

After discharge from service, Mr. Langford

no

Baltimore, Md.

London Park

4, 30, 71

Bureau

to 10 S. Washington, Jr.

FUNERAL DIRECTOR: IMPORTANT

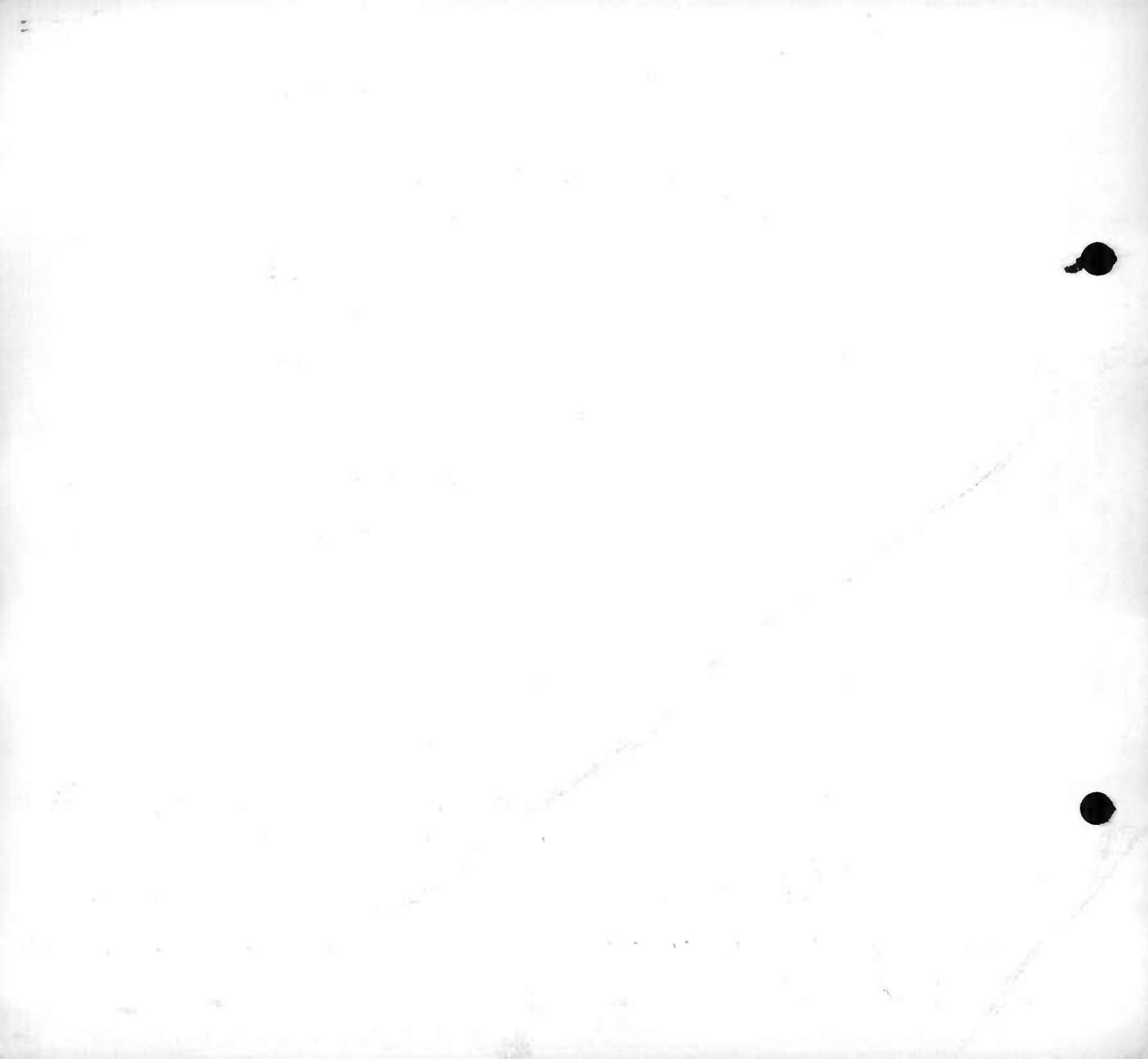
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	71 3884
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>EMMA V. McCourt</i>		2. DATE AND HOUR OF DEATH <i>4-17-71 930 A M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>001129 Falls Hill Road</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1307</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1129 Falls Hill Road</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-19-97</i>	9. AGE (In years lost birthday) <i>73</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>213-20-7289</i>		17. INFORMANT ADDRESS <i>21214</i> <i>Charles Mcburt 6210 Plymouth Rd</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Central vascular accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arterio-sclerotic C-V System</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>10 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 1960</i> to <i>April 17 1971</i> , that (I) (we) last saw the deceased alive on <i>April 15 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Allan Linn</i>				23B. DATE SIGNED <i>4/20/71</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-20-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 21 1971</i> 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
25C. FUNERAL DIRECTOR				ADDRESS <i>3615 Chestnut Ave.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3885	
C-636 71 3885		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) James Carter B.		2. DATE AND HOUR OF DEATH April 17, 1971 2:30 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND 805 B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 Good SAMARTIAN Hospital Belvedere & Loch Raven		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2041 Cliftwood Ave	
5. SEX male	6. RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 15, 1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK. Jett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 208-0-3531-A	
17. INFORMANT LETTIE CARTER		ADDRESS 2041 Cliftwood Ave	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic Shock 3 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Congestive Heart Failure 9 years	
		(C) Obstructive Pulmonary Disease 9 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Benign prostatic hypertrophy 1 year	
19A. DATE OF OPERATION 0 none	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED xxx	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) xxx	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) xxx	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) xxx	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? xxx	
22. I certify that (I) (this hospital) attended the deceased from April 2, 19 71 to April 17, 19 71 that (I) (we) last saw the deceased alive on April 17, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. xxx			
23A. SIGNATURE George H. Sack, Jr. MD.		23B. DATE SIGNED April 17, 1971	
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.		23D. ADDRESS 5600 Loch Raven Blvd. Balto. Md, 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4/20/71	24C. NAME OF CEMETERY OR CREMATORY MT AUBURN & KM	24D. LOCATION (City, town, or county) (State) BALTO md
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971	25B. NAME OF REGISTRAR John E. Fisher, MD.	25C. FUNERAL DIRECTOR DONALD E. LOVER / 1701 N. PATTERSON PK.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

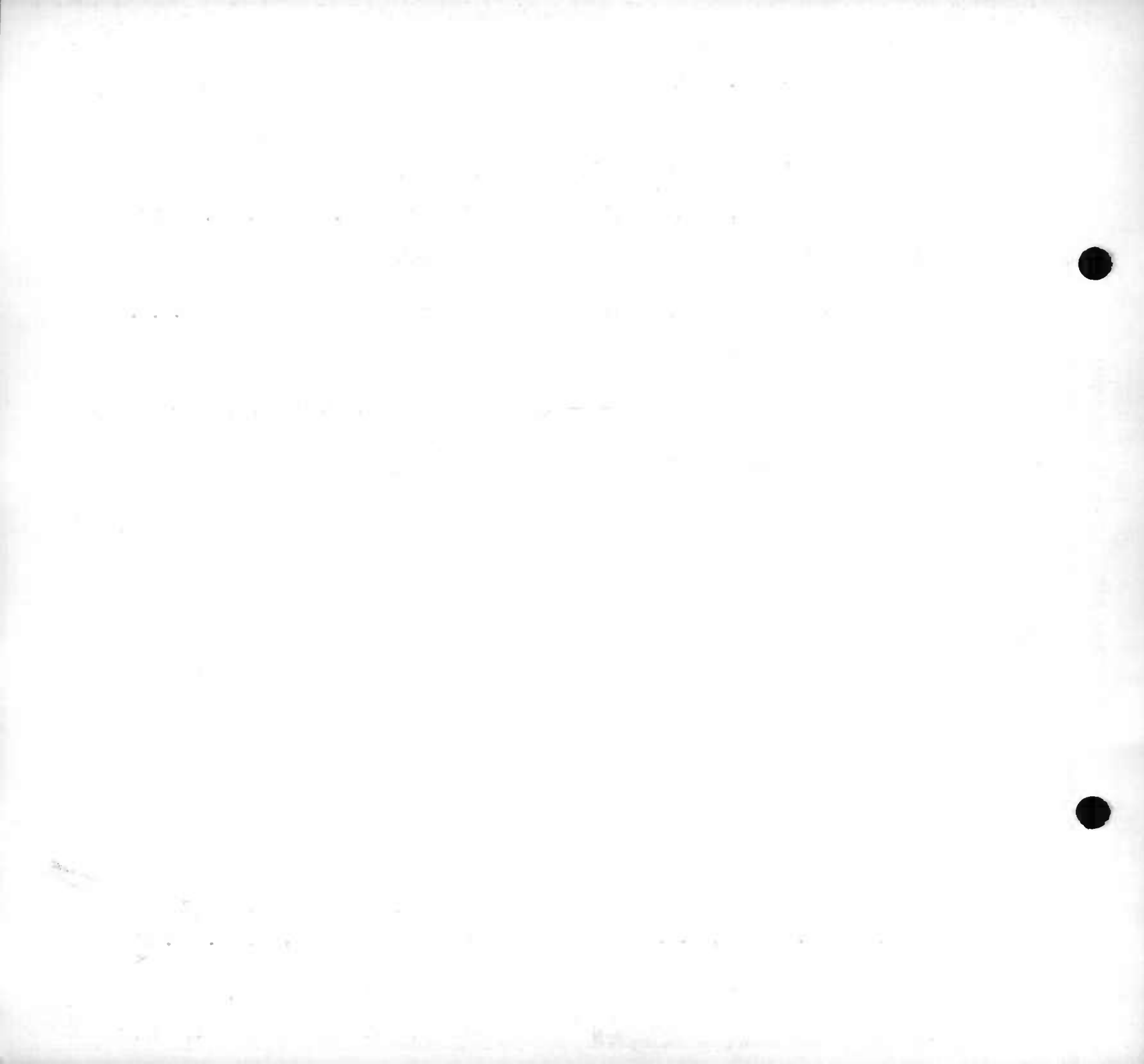
BALTIMORE CITY HEALTH DEPARTMENT				71 3886	
1-360 71 3886				71 3886	
BIRTH NO. 1-360 71 3886				REG. NO. 71 3886	
1. NAME OF DECEASED (Type or Print) TYRONE A. LOWMEYER, JR.				2. DATE AND HOUR OF DEATH APRIL 10, 1971 5:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 802	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M				6. DATE OF BIRTH 9/9/70	
7. RACE negro				9. AGE (in years, last birthday) 81 YRS.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jesse Lee Lowmeyer				14. MOTHER'S MAIDEN NAME Jesse Lee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no	
17. INFORMANT Dr. Niedengard				ADDRESS Johns Hopkins Hosp	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE - ACUTE EXACERBATION				20 MINUTES	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: TRACHEAL STENOSIS AND AGENESIS OF RIGHT LUNG AND QUESTIONABLE CONGENITAL HEART DEFECT				SINCE BIRTH	
(B) DUE TO, OR AS A CONSEQUENCE OF: CHROMOSOMAL ANOMALY WITH MULTIPLE CONGENITAL ANOMALIES				SINCE CONCEPTION	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2 NOV 71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 7 1971 to APRIL 10 1971 that (I) (we) last saw the deceased alive on APRIL 9 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee Niedengard M.D. DEGREE				23B. DATE SIGNED April 10, 1971	
23C. PHYSICIAN'S NAME (Type) Lee Niedengard MD				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-71		24C. NAME of CEMETERY or CREMATORY Mount Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 21 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Donald E. Glover ADDRESS 1701-03 Pattern PK Ave.			

1919 E. C. ...
Baltimore Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 3887	
7-432 71 3887		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Donald J. Fultz		2. DATE AND HOUR OF DEATH April 20, 1971 1:31:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1107 Dlong Rd., Balto. Md. 21228			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-38
9. AGE (In years last birthday) 32		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Clerk A & P		10B. KIND OF BUSINESS OR INDUSTRY Unemployed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Davenport Fultz		14. MOTHER'S MAIDEN NAME Gertrude Gerstenhaver	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-36-9433	
17. INFORMANT BCH Records: Baltimore, Maryland 21224		ADDRESS 4940 Eastern Avenue	
18. 20401 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Sepsis DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Acute Lymphoblastic leukemia DUE TO, OR AS A CONSEQUENCE OF:	
(C)		18 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 2 1971 to April 20 1971 that (I) (we) last saw the deceased alive on April 20 1971 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Thomas R. Griggs, M.D.		23B. DATE SIGNED 4/20/71	
23C. PHYSICIAN'S NAME (Type) Thomas R. Griggs, M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71	
24C. NAME OF CEMETERY or CREMATORY Lakeview Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Witzke, 1630 Edmondson Ave., 21228	
25C. FUNERAL DIRECTOR		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

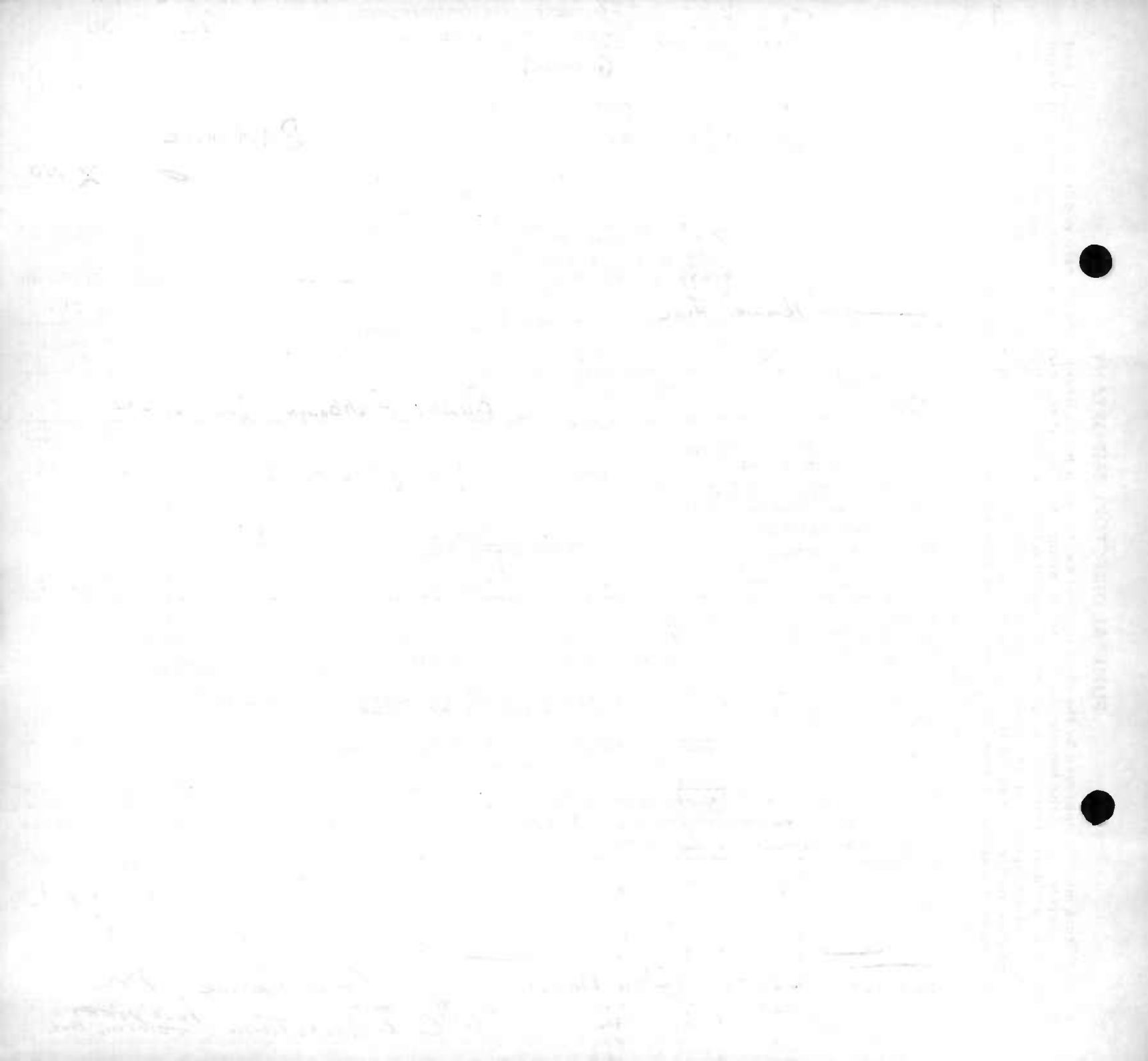
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3888	
<p>S-536 71 3888</p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Marcelle Santerre</p>		<p>2. DATE AND HOUR OF DEATH 4-19-71 1:30 P. M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.S. Public Health Service Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 137 So. Symington Avenue</p>			
<p>5. SEX Female</p> <p>6. RACE Cauc</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 7 Aug-1894</p> <p>9. AGE (in years last birthday) 76</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) France</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		<p>13. FATHER'S NAME Charles Devanlay</p>			
<p>14. MOTHER'S MAIDEN NAME Marie Diard</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>			
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS Records-US Public Health Service Hospital</p>			
<p>18. I CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Myocardial Infarct</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) yes</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Apr. 5, 1971 to Apr. 19 1971 that (I) (we) lost saw the deceased alive on Apr. 19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE R. Roger Little, MD</p>				<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) R. Roger Little, M. D.</p>				<p>23D. ADDRESS U.S. Public Health Service Hospital, Balto.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Cremation</p>		<p>24B. DATE 4/22/71</p>		<p>24C. NAME of CEMETERY or CREMATORY Baltimore National</p>	
<p>24D. LOCATION Baltimore, Md.</p>		<p>25A. DATE REC'D BY HEALTH DEPT. APR 21 1971 25B. NAME OF REGISTRAR R. Roger Little, MD.</p>			
<p>25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228</p>				<p>ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

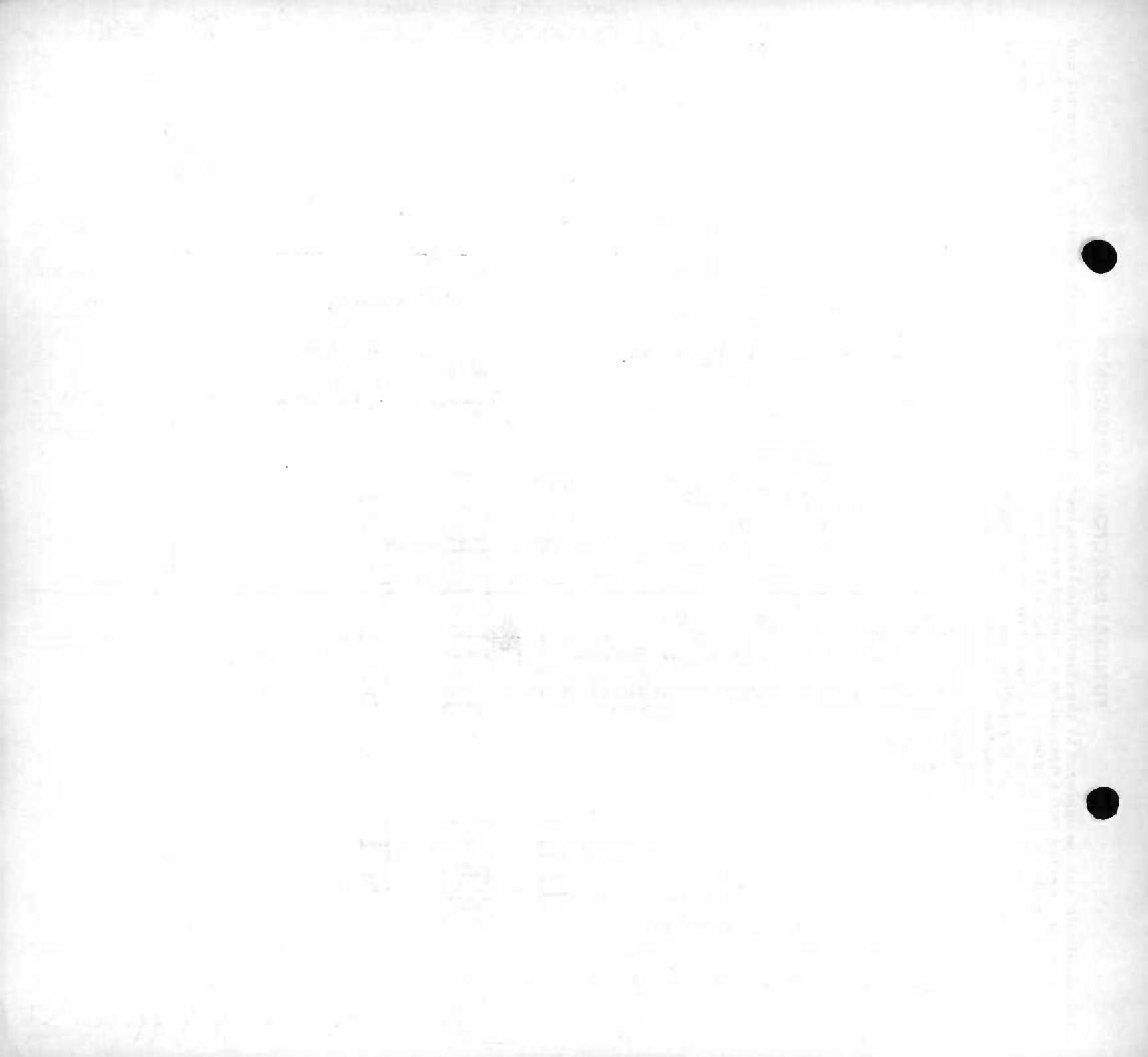
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 71 3889									
F-212 71 3889									
1. NAME OF DECEASED (Type or Print) <u>FISH BAUGH, ANNA L.</u> (or <u>Annie</u>)					2. DATE AND HOUR OF DEATH <u>4-19-71</u> <u>4:20 PM</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GEN. HOSP.</u> <u>43</u>					A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>				
					E. STREET AND NUMBER <u>1929 VICTORY DRIVE</u>				
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-02</u>		9. AGE (In years last birthday) <u>69</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<u>None</u>		<u>None</u>		<u>MD.</u>		<u>U.S.A.</u>			
13. FATHER'S NAME <u>William Roelecke</u>					14. MOTHER'S MAIDEN NAME <u>Anna Hilderbrandt</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.				
					17. INFORMANT <u>Russell Fishbaugh, Same as #14</u>				
18. <u>5-25-X I</u>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hepatic failure</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>Chronic cholecystitis</u> 3 years.				
					(C) <u>Cholangitis</u> 2 months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2-25</u> 19 <u>71</u> to <u>4/19/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/19/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Harjit Singh M.D.</u>					23B. DATE SIGNED <u>4/19/71</u>				
23C. PHYSICIAN'S NAME (Type) <u>SINGH HARJIT MD</u>					23D. ADDRESS <u>3001 S. HANOVER ST.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>4-23-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		
24D. LOCATION (City, town, or county) <u>Glen Burnie, Md</u>					24E. (State) <u>MD</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson</u>			
					ADDRESS <u>1050 YORK RD Towson, Md</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3890</u>	
BIRTH NO. <u>N-2437-04471</u>		CERTIFICATE OF DEATH <u>3890</u>			
1. NAME OF DECEASED (Type or Print) DORIS NICOLAIDIS			2. DATE AND HOUR OF DEATH April 16 1971 5 ²⁵ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2406 E. FAYETTE STREET</u>		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-71</u>	9. AGE (In years last birthday) <u>28</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>EMMANUEL A. NICOLAIDIS</u>			14. MOTHER'S MAIDEN NAME <u>LEONA SMITH.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Mrs. Leona Nicolaidis - 2406 E. Fayette St</u> ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>054X1</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Herpes Encephalitis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>4/5/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain Biopsy to Diagnose Disease</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>March 28</u>, 19<u>71</u> to <u>April 16</u>, 19<u>71</u> and that (2) (we) lost saw the deceased alive on <u>April 16</u>, 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan E. Zuckerman</u>			23B. DATE SIGNED <u>4/16/71</u>		23C. PHYSICIAN'S NAME (Type) ALAN E. ZUCKERMAN
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>4-19-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>GLEN HAVEN Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		
25B. NAME OF REGISTRAR <u>John E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>John E. Fisher - 2334 Jefferson St.</u> ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
71 3891 CERTIFICATE OF DEATH					REG. NO. 71 3891					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Edward K Kimball, Sr.</i> </div> <div> 2. DATE AND HOUR OF DEATH <i>4/17/71</i> <i>11 00 A.M.</i> </div> </div>										
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION <i>38 Univ. of Md. Hospital</i> </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE <i>MARYLAND</i> </div> <div> B. COUNTY <i>Balto.</i> </div> </div>					
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					8. DATE OF BIRTH <i>5-20-28</i> 9. AGE (In years last birthday) <i>42</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Correctional Officer</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>CITY JAIL</i>					
11. BIRTHPLACE (State or foreign country) <i>Md</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>					13. FATHER'S NAME <i>Edward S. Kimball</i> 14. MOTHER'S MAIDEN NAME <i>Anna Branch OTHO</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>218-22-4642</i> 17. INFORMANT <i>Mrs. Betty Mae Hoyle - 54 Banker Ave.</i>					
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Hepatic failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Rheumatic heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>poor Double Valve Replacement</i> </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>										
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>3-16-71</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4-17</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date <i>4-17</i> 19 <i>71</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>H. Jae Ihm M.D.</i> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <i>4-17-71</i>		
23C. PHYSICIAN'S NAME (Type) <i>H. JAE IHM M.D.</i>								23D. ADDRESS <i>Univ of Md Hosp.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>4-20-71</i>			24C. NAME of CEMETERY or CREMATORY <i>GARDENS OF FAITH Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 21 1971</i>			25B. NAME OF FUNERAL STRA			25C. FUNERAL DIRECTOR <i>J. A. Miller Funeral Home</i>			ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 3892</u>	
BIRTH NO. <u>S-436</u>		71 3892		1. NAME OF DECEASED (Type or Print) <u>William E Slater</u>		2. DATE AND HOUR OF DEATH <u>4/18/71 6:40 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>703</u>			
5. SEX <u>MALE</u>				6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10/19/08</u>				9. AGE (In years last birthday) <u>62</u>		10. UNDER 1 Yr. Months <u> </u> Days <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM SLATER</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE HITROTH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214 18 9245</u>		17. INFORMANT <u>Mrs. Mary S. Westerfield</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.41</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Emphysema</u> <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>adult life</u> <u>adult life</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> 19 <u>71</u> to <u>4-18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-18</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Bruce A. Reitz</u>				23B. DATE SIGNED <u>4-18-71</u>		23C. PHYSICIAN'S NAME (Type) <u>BRUCE A. REITZ, M.D.</u>	
23D. ADDRESS <u>601 N. BROADWAY 2205</u>				23E. FUNERAL DIRECTOR <u>Spertley & Geller</u>		23F. ADDRESS <u>-2334 Jefferson St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>4-22-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL CEM.</u>	
24D. LOCATION (City, town, or county) <u>BALTO, MD.</u>				24E. STATE		25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>	
25B. NAME OF REGISTRAR <u>John E. Taylor, Md.</u>				25C. FUNERAL DIRECTOR <u>Spertley & Geller</u>			

XX

1984

1984

XX

1984

1984

1984

1
H 500

71 3893

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3893

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Danny Lee Hamm		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year April 18, 1971 Hour 1:34 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-15-1951		10. AGE (In years lost birthday) 19 II Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest O. Hamm		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loader	
15. MOTHER'S MAIDEN NAME Pecola Watson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Ernest O. Hamm	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3727 Reisterstown Road 1512	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 4-18-71 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot during altercation		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/18/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-1971	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		25D. ADDRESS 3035 W. NORTH AV	

MADE IN THE U.S.A. DATE OF DEATH

NAME

AGE

SEX

DATE

TIME

PLACE

CAUSE

MANNER

INSTRUMENT

WITNESSES

DOCTOR

MINISTRY

OFFICE

REGISTRATION

NUMBER

DATE

TIME

PLACE

CAUSE

MANNER

INSTRUMENT

WITNESSES

DOCTOR

MINISTRY

OFFICE

REGISTRATION

NUMBER

DATE

TIME

PLACE

CAUSE

MANNER

INSTRUMENT

WITNESSES

DOCTOR

MINISTRY

OFFICE

REGISTRATION

NUMBER

DATE

ACADEMIC & BOND

ALL CONTENT

BALTIMORE CITY HEALTH DEPARTMENT

71 3894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 "3894

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Willie Moore		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour Month Day Year Hour 4 20 71 10:28 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 20 71 10:28 a.m.	
6. SEX male		7. RACE colored	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 10-28-1901		10. AGE (in years lost birthday) 69	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Dennis	
14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2001		15. CITY OR TOWN Baltimore	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-09-6702	
18. INFORMANT Mrs. Ellen Moore		19. ADDRESS 13 N. Monroe Street	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		20. DATE OF OPERATION 4-24-1971	
21. AUTOPSY? (Yes or No) no		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. TIME (Month) (Day) (Year) (Hour) (APPROX.)		24. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
25. HOW DID INJURY OCCUR?		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.	
29. DATE REC'D BY HEALTH DEPT. APR 21 1971		30. NAME OF REGISTRAR Robert E. Fisher, M.D.	
31. DATE OF BURIAL CREMATION, REMOVAL (Specify) Burial		32. DATE 4-24-1971	
33. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		34. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
35. FUNERAL DIRECTOR NUTTER FUNERAL HOME		36. ADDRESS 3035 W. NORTH AVENUE	

ACADEMIC BOND

HAIR CRAFT LMT

WALKER PAPER CO

1972

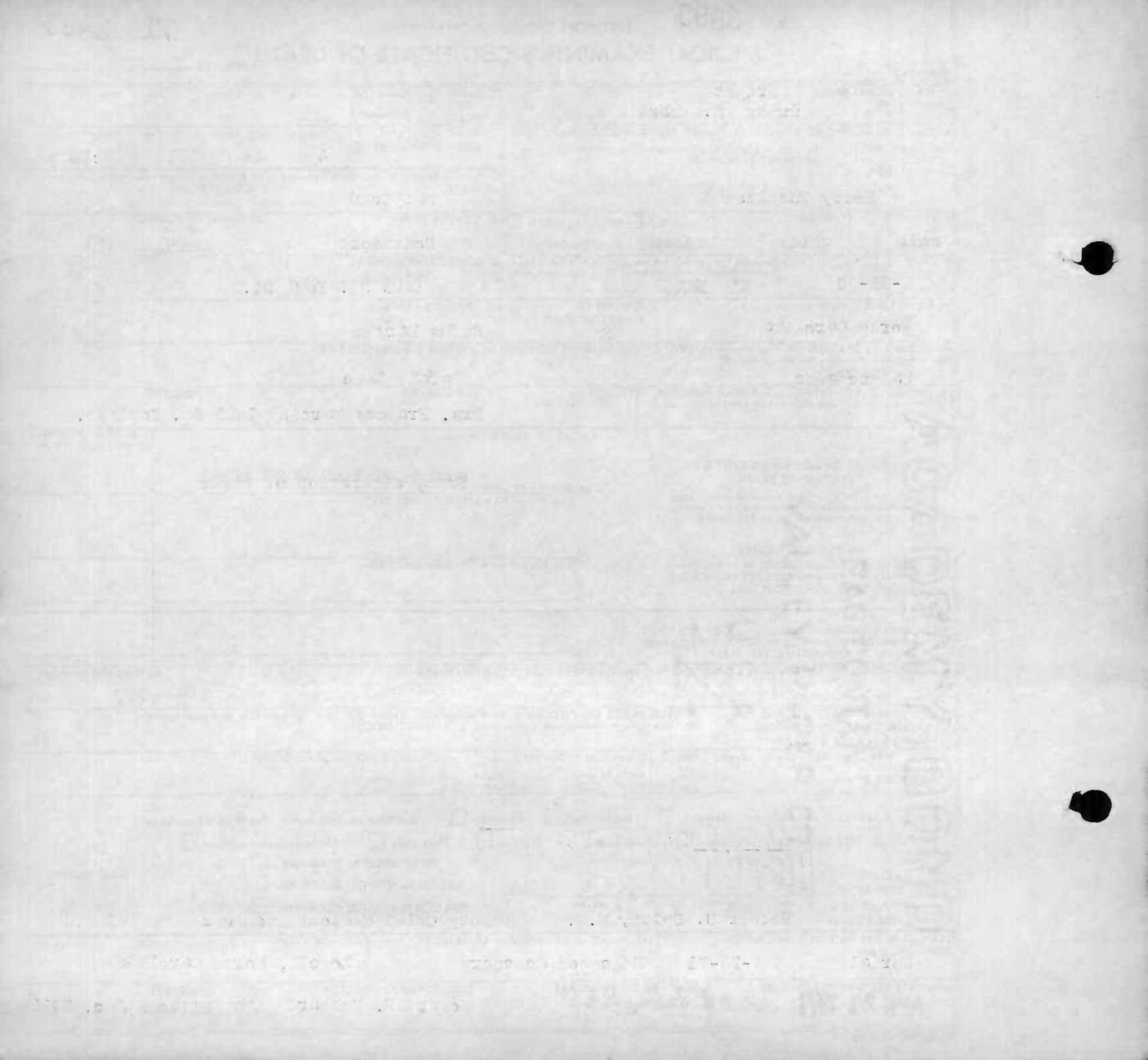
1972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Bright Brite S. Martin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	M.
(If not in hospital or institution, give street address or location)		4		19	71	7:20 p	M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1205		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX male	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1605 St. Paul St.			
9. DATE OF BIRTH 2-11-30		10. AGE (In years last birthday) 41		11. BIRTHPLACE (State or foreign country) North Carolina			
12. CITIZEN OF USA		13. FATHER'S NAME Rufus Martin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance			
15. MOTHER'S MAIDEN NAME Sarah Lane		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unk		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Frances Martin	
19. CAUSE OF DEATH 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. DATE OF OPERATION 2			
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		24. HOW DID INJURY OCCUR?	
25. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		28. HOW DID INJURY OCCUR?	
29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Normal causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner		32. DATE SIGNED 4/20/71	
33. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		34. 24B. DATE 4-24-71		35. 24C. NAME OF CEMETERY or CREMATORY Edgewood Cemetery		36. 24D. LOCATION (City, town, or county) (State) Lowell, North Carolina	
37. 25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		38. 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		39. 25C. FUNERAL DIRECTOR Howard H. Hubbard		40. ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 3896		71 3896	
BIRTH NO. <u>A-400</u>		1. NAME OF DECEASED <u>Washington 71</u>		2. DATE AND HOUR OF DEATH <u>APRIL 19, 1971 12:20 P</u>	
(Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>AHL, KORI ANN</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto.</u>	
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10/25/69</u>		9. AGE (In years last birthday) <u>18 MONTHS</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON XXXX</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MICHAEL AHL</u>	
14. MOTHER'S MAIDEN NAME <u>MELODY METHVIN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>ST AGNES HOSPITAL RECORDS</u>	
17. INFORMANT <u>ST AGNES HOSPITAL RECORDS</u>		18. <u>464X</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Upper Respiratory Infection (Clinical)</u> <u>Autopsy Finding (Pneumonia)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>APRIL 18</u> 19 <u>71</u> to <u>APRIL 19</u> 19 <u>71</u> and that (X) (we) lost saw the deceased alive on <u>APRIL 19</u> 19 <u>71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Leomina D Escalante</u>		23B. DATE SIGNED <u>4-19-71</u>		23C. PHYSICIAN'S NAME (Type) <u>LEOMINA D ESCALANTE MD</u>	
23D. ADDRESS <u>BALTO MD 21229</u>		23E. NAME OF REGISTRAR <u>Howard H. Hubbard</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>4-21-71</u>		24C. NAME of CEMETERY or CREMATORY <u>LOUDON PARK CREMATORY</u>	
24D. LOCATION <u>BALTIMORE, MD.</u>		24E. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR <u>4107 WILKENS AVE. 21229</u>	

Cause of Death
8/17/71 A Cerebral Edema + Hypoxic
neuroal

B - Tracheitis, viral
Additional Information from letter
from Path. Dept. St. Agnes Hosp.
Filed in Bur of Biostatistics

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-500 71 3897		BALTIMORE CITY HEALTH DEPARTMENT		71 3897	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) AGNES R. SCHAMMA			2. DATE AND HOUR OF DEATH APRIL 18, 1971 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 601 BEECHFIELD AVENUE			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2541 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 601 BEECHFIELD AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1890	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALEXANDER OEHLER			14. MOTHER'S MAIDEN NAME KATIE CLARK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213509315		17. INFORMANT ADDRESS M JAMES E. SCHAMMA 601 Beechfield Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1 (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause 1A) stating the UNDERLYING CONDITION lost. CA. OF LEFT BREST 20 months 6 years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 to 4/18/71 that (I) (we) lost saw the deceased alive on 4/18/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Grace E. Jones, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Typal) GRACE JONES				23D. ADDRESS 12 WALKER AVE. PIKESVILLE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BRI BURIAL		24B. DATE 4-22-71		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION BALTIMORE, MD.		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR APR 21 1971 Robert E. Huber, Jr.		25B. FUNERAL DIRECTOR HOWARD H. HUBBARD		25C. ADDRESS 4107 WILKENS AVE. 21229	

1942

1943

1944

1945

1946

1947

1948

1949

1950

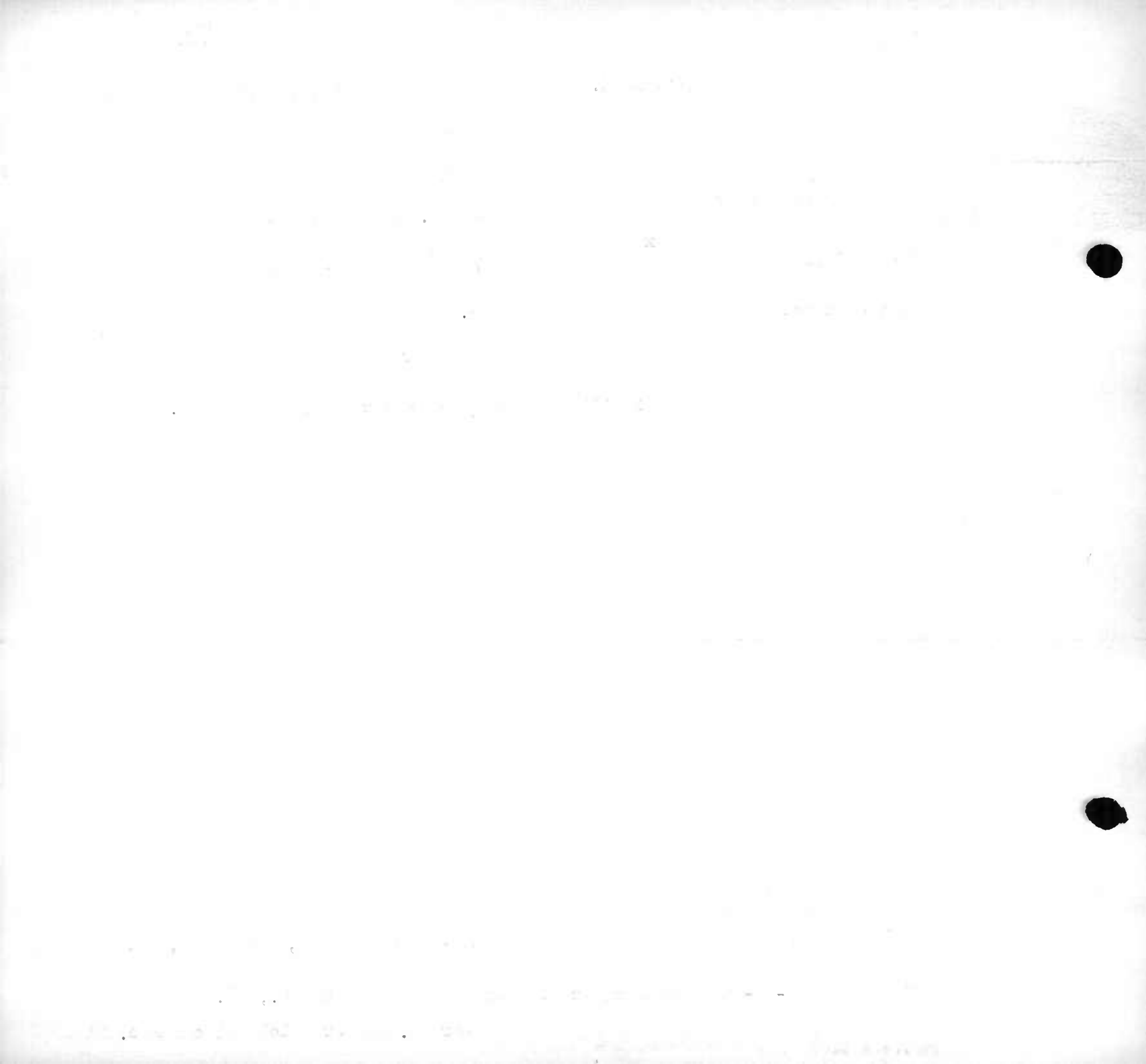
1951

1952

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

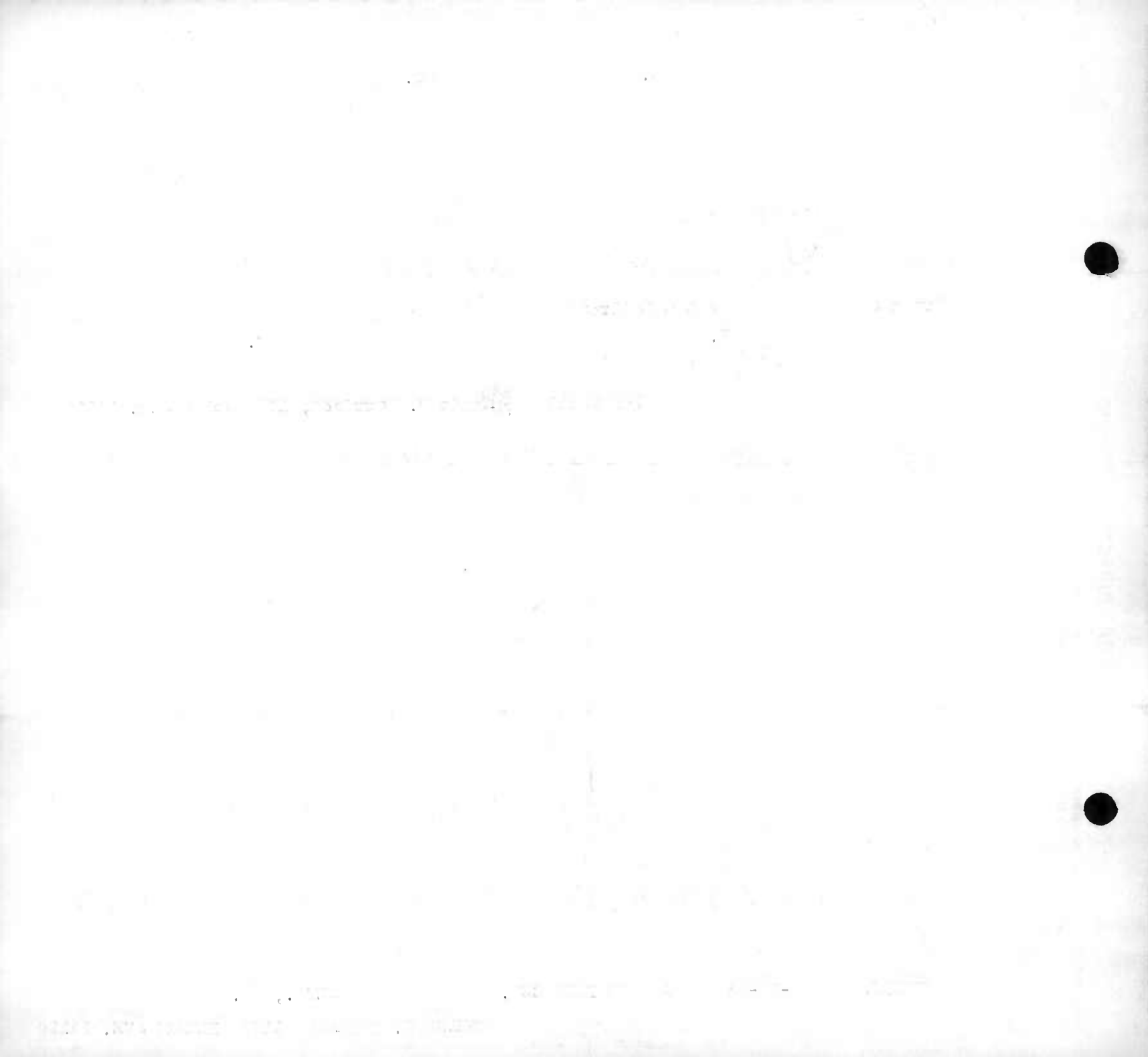
<p>P-420 71 3898</p> <p>BIRTH NO.</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 3898</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">PAULUS, Eleanor C.</p>			<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">April 18, 1971 11:15 PM M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE B. COUNTY</p> <p style="text-align: center;">MARYLAND</p>		
<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">40 ST. AGNES HOSPITAL Emergency Room</p>			<p>C. CITY OR TOWN D. INSIDE CITY LIMITS?</p> <p style="text-align: center;">Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		
<p>E. STREET AND NUMBER</p> <p style="text-align: center;">408 S. Payson Street</p>			<p>6. DATE OF BIRTH 7. AGE (In years last birthday)</p> <p style="text-align: center;">7/18/19 51 52</p>		
<p>8. SEX 9. RACE</p> <p style="text-align: center;">Female White</p>			<p>10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center;">Machine operator</p>			<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="text-align: center;">Md.</p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="text-align: center;">USA</p>		
<p>13. FATHER'S NAME</p> <p style="text-align: center;">unknown</p>			<p>14. MOTHER'S MAIDEN NAME</p> <p style="text-align: center;">unknown</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;">NO</p>			<p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;">214227014</p>		
<p>17. INFORMANT ADDRESS</p> <p style="text-align: center;">Jo Ann Potter 2005 Ramsay St. 21223</p>					
<p>18. CAUSE OF DEATH</p> <p style="text-align: center;">I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p style="text-align: center;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">II ANTECEDENT CAUSES</p> <p style="text-align: center;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>					
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?</p> <p style="text-align: center;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>					
<p>22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE 23B. DATE SIGNED</p> <p style="text-align: center;">Ching Hui Tsai M.D. 4/18/71</p>					
<p>23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS</p> <p style="text-align: center;">Ching-Hui Tsai, M.D. St. Agnes Hospital, Baltimore, Md.</p>					
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center;">BURIAL 4-22-71 Meadowridge Cemetery Howard Co., Md.</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS</p> <p style="text-align: center;">APR 21 1971 R. E. Taylor, Jr. Howard H. Hubbard 4107 Wilkens Ave. 21229</p>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-625		71 3899		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		71 3899	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES E. HARRISON Sr.						2. DATE AND HOUR OF DEATH 4/18/71 4:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 49 NORTH CHARLES GEN. HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21227 5300					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 49 NORTH CHARLES GEN. HOSPITAL						C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER SELMA AVE. 1711											
5. SEX MALE		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/2/07		9. AGE (In years last birthday) 63		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman				10B. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. HARRISON						14. MOTHER'S MAIDEN NAME ANNIE G. SWANN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 705056111		17. INFORMANT ADDRESS Annie G. Harrison, 1711 Selma Ave. 21227					
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) PULMONARY EMPHYSEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II						CAUSE OF DEATH PULMONARY EMPHYSEMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >4 years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 4/11 19 71 to 4/18 19 71 that (I) (we) last saw the deceased alive on 4/18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Daniilo V. Santos, M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/18/71			
23C. PHYSICIAN'S NAME (Type) DANILO V. SANTOS M.D.						23D. ADDRESS NORTH CHAS. GEN. HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-21-71		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK EEM.		24D. LOCATION (City, town, or county) (State) BALTO., MD.					
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Kelley, Jr.		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD		ADDRESS 4107 WILKENS AVE. 21229					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3900	
CERTIFICATE OF DEATH				REG. NO. 71 3900	
BIRTH NO. <u>S-363</u>		1. NAME OF DECEASED (Type or Print) <u>Bessie Stewart</u>		2. DATE AND HOUR OF DEATH <u>4/19/71</u> <u>12:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2101</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHN HOPKINS UNIVERSITY HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>638 DOVER ST.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-08</u>	9. AGE (In years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Edward Stewart</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Saunders</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Carrie, Richard Downswell, Jr.</u>	
18. <u>1990 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cachexia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Widespread Carcinoma</u>		CAUSE OF DEATH <u>Cachexia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Widespread Carcinoma</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>71</u> to <u>4/19</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>4/19</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Norman H. Revsner, MD</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>NORMAN H. REVSNER</u>		23D. ADDRESS <u>U. of Md. ER</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/24/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Family Plot</u>	
24D. LOCATION <u>Ashland</u>		24E. (City, town, or county) (State) <u>Virginia</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1971</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>H. W. Dabney</u>	
		ADDRESS <u>Ashland, VA.</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3901

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

David W. Brewington

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour 4 16 71 10:00 PM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 1512

6. SEX male 7. RACE colored B. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH 10-23-1923 10. AGE (In years last birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 3922 Park Heights Ave.

11. BIRTHPLACE (State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph A. Brewington

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed 14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Annie J. Autry

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 241-22-2031 18. INFORMANT Maryline Brewington 4639 Park Heights Ave.

19. E965X CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3832 Park Heights Ave. 1512

22D. TIME OF INJURY (APPROX.) 4 16 71 6:30 PM 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? shot during altercation23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 4/17/71

24A. BURIAL CREMATION, REMOVAL (Specify) Removal 24B. DATE 4/20/71 24C. NAME OF CEMETERY or CREMATORY North Side 24D. LOCATION (City, town, or county) (State) Fayetteville N.C.

25A. DATE REC'D BY HEALTH DEPT. APR 21 1971 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS 1727 N. Mount St.

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

10-2-1918

G-650

71

3902

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

3902

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN E. GREEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1114 N. Fulton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 16, 1971 6:25 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6-25-1920		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 160-16-7013	
18. INFORMANT John E. M. Green Jr.		ADDRESS	
19. 577.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hemoperitonum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Antecedent causes		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture Pseudocyst of pancreas	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) Chronic pancreatitis	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR William S. Phillips		ADDRESS 1727 N. Mount St.	

APPENDIX - NON

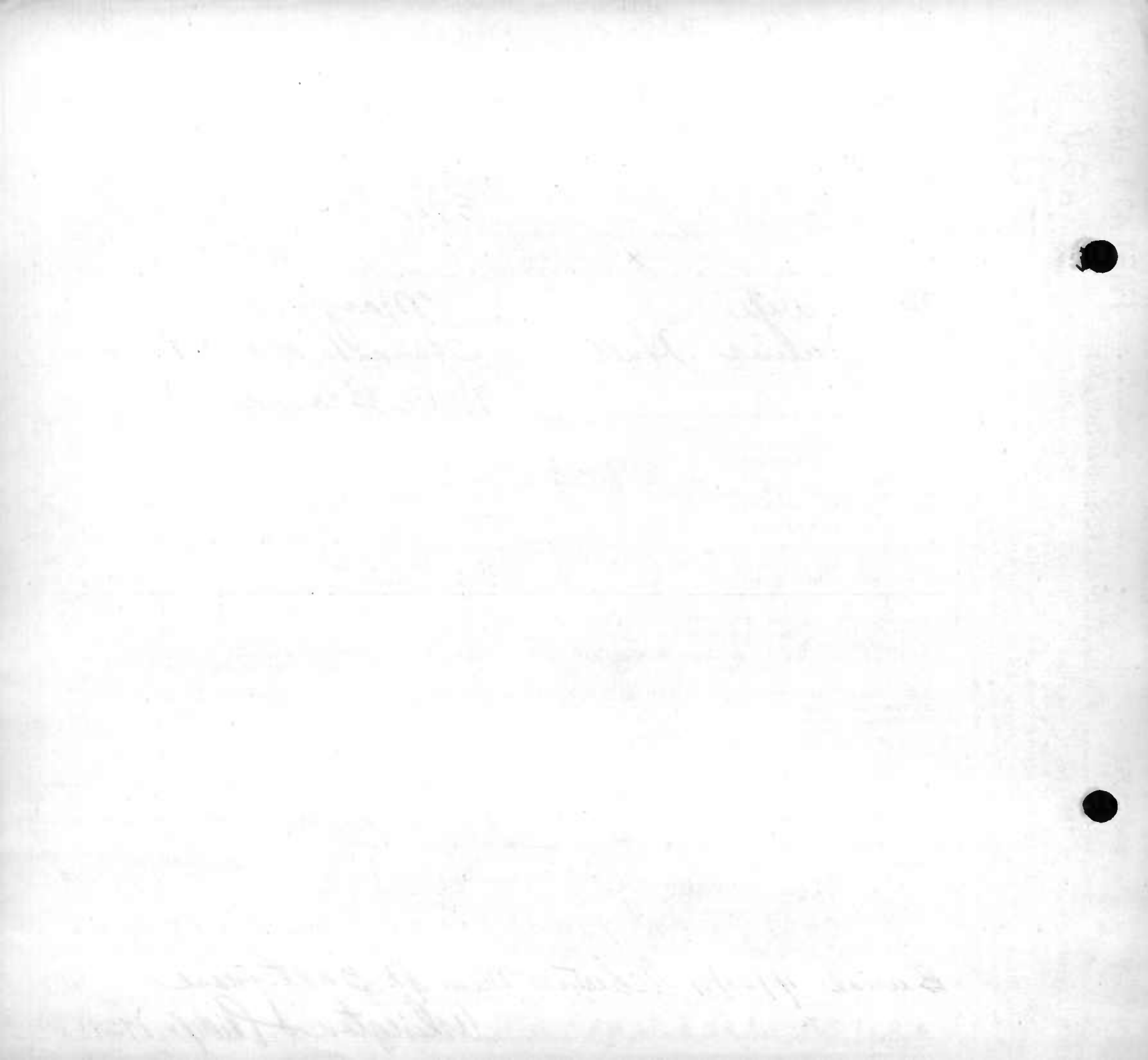
VALLEY - APED

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-453 71 3903				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3903	
1. NAME OF DECEASED (Type or Print) Nellie Hall Flint				2. DATE AND HOUR OF DEATH April 16 1971 12²⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1608			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mt Sinai Nursing Home 90 4613 Park Heights Ave Balto Md 21215				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3700 Cranston Ave.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/19/86	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (One kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Julius Hall			
14. MOTHER'S MAIDEN NAME Hannah M. N. Unknown				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Nellie Brown ADDRESS Same			
18. 5-60-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intestinal Obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Dehydration Chronic Pain Syndrome				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intestinal Obstruction (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Pain Syndrome (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 25 1971 to April 16 1971 , that (I) (we) last saw the deceased alive on April 14 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE LOUIS T. LARRY M.D.				23B. DATE SIGNED April 16 - 1971			
23C. PHYSICIAN'S NAME (Type) LOUIS T. LARRY M.D.				23D. ADDRESS 3502 W. Kogon Ave Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Ch. Baltimore Md.		24D. LOCATION (City, town, or county) (State) md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Wilmington A. Bridges		ADDRESS 1727 N. Mount	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3904	
BIRTH NO. S-353		71 3904		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) William Standly			2. DATE AND HOUR OF DEATH April 16, 1971 4:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1502		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.S. Public Health Service Hospital 3100 Wyman Park Drive Baltimore, Maryland 21211			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-5-01			9. AGE (in years last birthday) 69		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard			10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Henry Standly		
14. MOTHER'S MAIDEN NAME Lear Boye			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1926-1950		
16. SOCIAL SECURITY NO. 215-30-5180			17. INFORMANT ADDRESS Records-USPHS Hospital		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Carcinoma, Rt. lung, with metastases Gastric dilatation			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 6 mos. hours		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Apr. 7 1971 to Apr. 16 1971 that (we) last saw the deceased alive on Apr. 16 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE Samuel P. Ward, M.D.			23B. DATE SIGNED April 16, 1971		23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, Surgeon (R)
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 4-21-71		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK
24D. LOCATION BALTIMORE, MARYLAND			25A. DATE RECD BY HEALTH DEPT. APR 21 1971		
25B. NAME OF REGISTRAR V. E. Taylor, R.D.			25C. FUNERAL DIRECTOR ADDRESS ARLINGTON S. PHILLIPS-1727 N. Monroe st-21217		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3905</u>
C-400 71 3905				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
LELIA P. COLE		APRIL 14, 1971 11:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
001810 N. MOUNT STREET		MARYLAND 1502		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
F		COLORED		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
HOUSEWIFE				11-9-1892
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		12. CITIZEN OF WHAT COUNTRY
VIRGINIA		78		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Unknown		Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO		171-07-7552		JOHN F. COLE-1810 N. MOUNT STREET
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		2-3 mos		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ASHD & Permanent Congestive Heart Failure & Myocardial Infarction		
II		(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 2/10 1969 to present 1971 and that (I) (we) last saw the deceased alive on 3/23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Eljah Saunders				4/15/71
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
ELIJAH SAUNDERS		2300 GARRISON BLVD.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
BURIAL		4-17-71		ARBUTUS MEMORIAL PARK
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
APR 21 1971		Robert E. Taylor, M.D.		ARLINGTON S. PHILLIPS-1717-27 N. MONROE ST



1

B-635 71 3906 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3906

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lula Byrdine		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 17 71 6:55 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION 2625 Francis St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 71 6:55 p. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1303			
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Sept 22, 1893	10. AGE (In years last birthday) 78	E. STREET AND NUMBER 2625 Francis St.	
11. BIRTHPLACE (State or foreign country) Winnsboro, S. C.	12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Byrd Rev. James A. Byrdine	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Sarah Goins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO. 201-299-7043	18. INFORMANT Willie M. Hudgen 3323 Blane St. N. E. Wash. D	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE M.D. DATE SIGNED EXAMINER'S NAME (Type) Peter Lipkovic, M.D. 4/19/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-25-71	24C. NAME OF CEMETERY or CREMATORY Blackjack Bapt, Church Ceme.	24D. LOCATION (City, town, or county) (State) Winnsboro, S. C.
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971	25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR Morton & Dyett F. H. ADDRESS Baltimore, Md. 21217 1701 Laurens St	

VS 151-REV. 1/1/68

5/14/71 - Correction form from funeral director.

Life.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-453 71 3907		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
BIRTH NO.		CERTIFICATE OF DEATH		71 3907	
1. NAME OF DECEASED (Type or Print) NAMES		BLOUNT		2. DATE AND HOUR OF DEATH 4-20-71 945 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 1607		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 DUKELAND HSG. HOME		E. STREET AND NUMBER 1501 DUKELAND STREET			
5. SEX MALE	6. RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-06	9. AGE (In years last birthday) 64 YRS	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville Co, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Abner Blount		14. MOTHER'S MAIDEN NAME Fannie Blount	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 229-09-63034		17. INFORMANT ADDRESS 3038 WINSO R AVENUE	
18. 4-26-71		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism		1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cerebral Accident DUE TO, OR AS A CONSEQUENCE OF:		2 years	
(C) Arterial Abscess				2 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10-31-1970 to 4-20-1971 that (I) (we) last saw the deceased alive on 4-19-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Cervical D. Smith		23B. DATE SIGNED 4-20-71		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS DEGREE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-71	
24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 21 1971	
25B. NAME OF REGISTRAR Blount		25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens Street	

100-100000

100-100000

100-100000
100-100000

100-100000

100-100000 100-100000 100-100000 100-100000

100-100000 100-100000 100-100000

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

1. NAME OF DECEASED
(Type or Print) Vanessa Talliferro

2. DATE OF DEATH Known ☒ Month 4 Day 19 Year 71 Hour 12:05 M. P.
Estimated ☐

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 4115 Bonner Rd.

3. DATE PRONOUNCED DEAD Month 4 Day 19 Year 71 Hour 12:05 M. P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1502

6. SEX female **7. RACE** colored **8. MARRIED** ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH Oct 11, 1953 **10. AGE** (In years lost birthday) 18 **11. BIRTHPLACE** (State or foreign country) Baltimore, Maryland

12. CITIZEN OF U.S.A. **13. FATHER'S NAME** Alvin Taliaferro

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **14B. KIND OF BUSINESS OR INDUSTRY** **15. MOTHER'S MAIDEN NAME** Alma Wallace

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **17. SOCIAL SECURITY NO.** **18. INFORMANT** Alma Wallace **ADDRESS** 1542 N. Fulton Avenue

19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 2 **20B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **21. AUTOPSY?** (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. **22B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **22C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) **22E. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **22F. HOW DID INJURY OCCUR?**

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ **and that on this basis, death in my opinion resulted from:** Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner H. Spitz **M.D.** **CHIEF MEDICAL EXAMINER** ☐ **DATE SIGNED** 4/20/71
EXAMINER'S NAME (Type) WERNER H. SPITZ M.D. **ASSISTANT MEDICAL EXAMINER** ☐ **ASSOCIATE MEDICAL EXAMINER** ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial **24B. DATE** 4-23-71 **24C. NAME OF CEMETERY or CREMATORY** Western Star Cemetery **24D. LOCATION** (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. APR 21 1971 **25B. NAME OF REGISTRAR** Robert E. Taylor, R.D. **25C. FUNERAL DIRECTOR** Morton & Dyett F. H. **ADDRESS** 1701 Laurens Street 21217

W. J. ...

...

...

...

...

...

...

...

Alvin ...

...

...

Alvin ...

Alvin ...

...

WALBURY

...

...

...

...

...

1

J-520 71 3909 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3909

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAJOR MC KENNETH JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1400 blk. Bank St. in Sun Cab		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 1971 3:15 a.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-5-34		10. AGE (In years lost birthday) 37	
11. BIRTHPLACE (State or foreign country) Wake Forest, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Nancy Jones		ADDRESS Macon Jones, Jr. 1913 E. 20th St. 21218	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple gunshot wounds of chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) cab	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1400 blk. Bank St. 301		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4-17-71 3:07 a.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot while trying to rob an off duty policeman.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4-23-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Jones, Jr.	
25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.			

VS 151-REV. 1/1/68

3886

11

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY SP-6 JRS/STP

DATE 10-10-2001 BY SP-6 JRS/STP

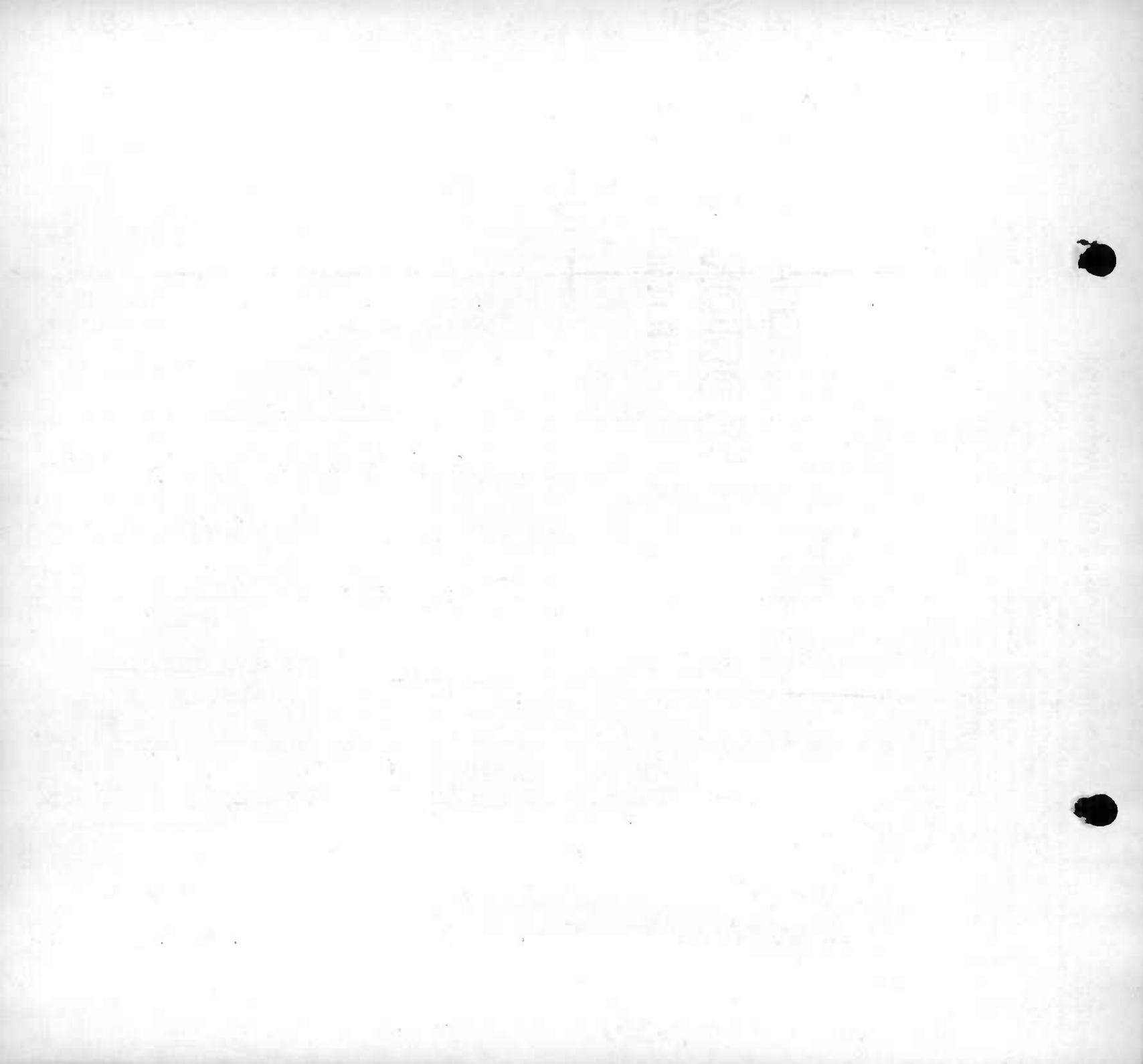
DATE 10-10-2001 BY SP-6 JRS/STP

DATE 10-10-2001 BY SP-6 JRS/STP

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

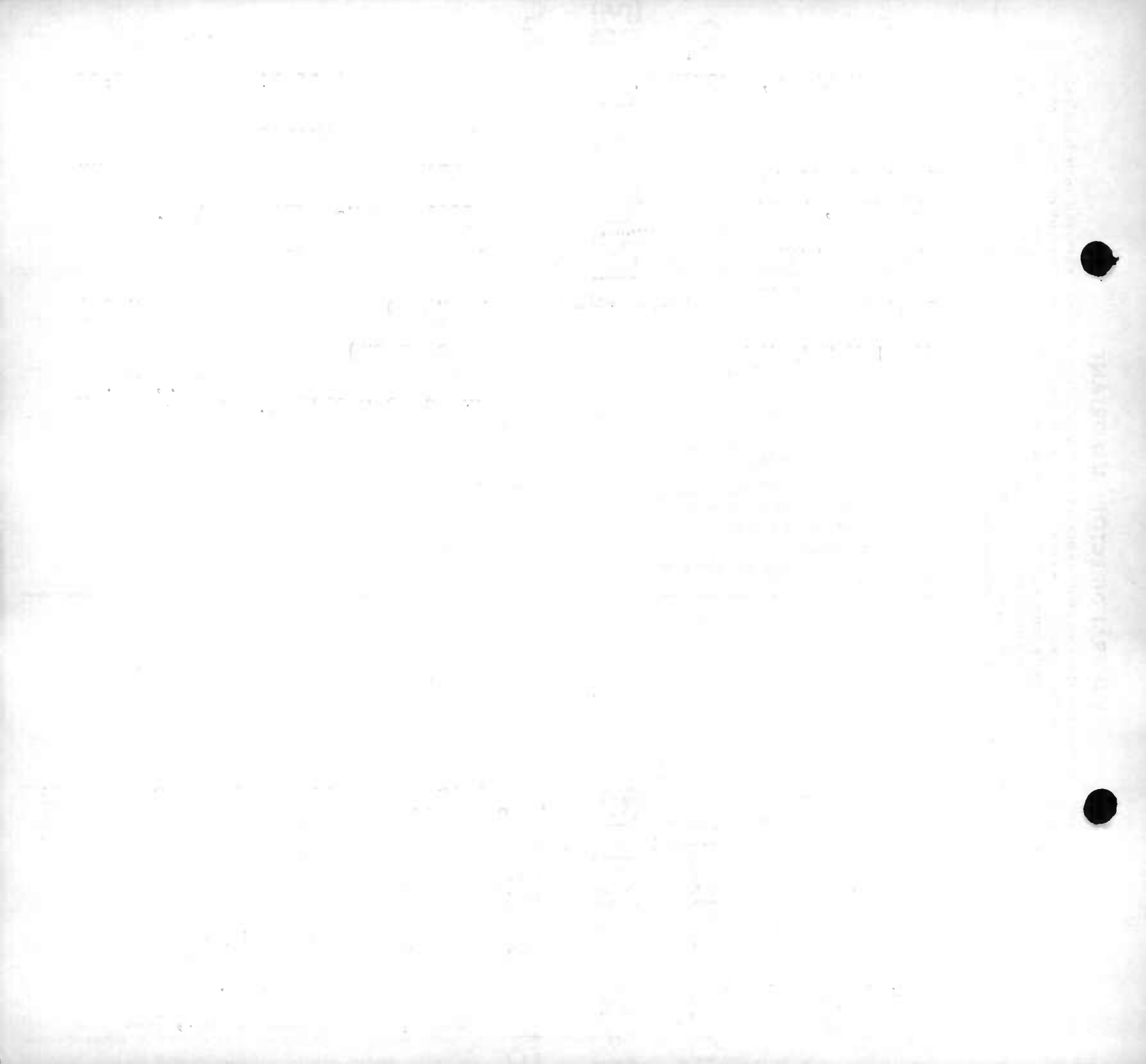
P-626 71 3910				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3910	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Elenor Martha Parker				2. DATE AND HOUR OF DEATH 4-16-71 7:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2112 McCulloh Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2112 McCulloh St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-89		9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk				14. MOTHER'S MAIDEN NAME unk			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ann Jackson 836 Glenwood Ave. 21212			
18. 4/10/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction 12 hrs. (B) Hypertensive Art+scler. Heart Dis. Unknown (C) Chronic Brain Syndrome Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/2 19 69 to 4/16 19 71 , that (I) (we) last saw the deceased alive on 4/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E.E. Holt				23B. DATE SIGNED 4/19/71		23C. PHYSICIAN'S NAME (Type) E.E. Holt, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4-21-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A.A. Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1971		25B. NAME OF REGISTRAR Robert E. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. Marshall W. Jones, Jr. 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 3911				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3911	
1. NAME OF DECEASED (Type or Print) HELLMAN, AUGUST C.				2. DATE AND HOUR OF DEATH 4 20 71 5:55 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL BALTIMORE, MARYLAND				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 5001 APT H-WESTLAND BLVD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 09 09	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY Phelps Packing Co		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME WILLIAM HELLMAN				14. MOTHER'S MAIDEN NAME (NAGENTAST) Catherine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT BALTO., MD. ST AGNES HOSPITAL, WILKENS & CATON AVE			
18. 450X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4 12 1971 to 4 20 19 71 that (1) (we) last saw the deceased alive on 4/20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Romualdo R. Dator, M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Romualdo R. Dator, M.D.	
				23D. ADDRESS St Agnes Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71		24C. NAME of CEMETERY or CREMATORY Lakeview Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

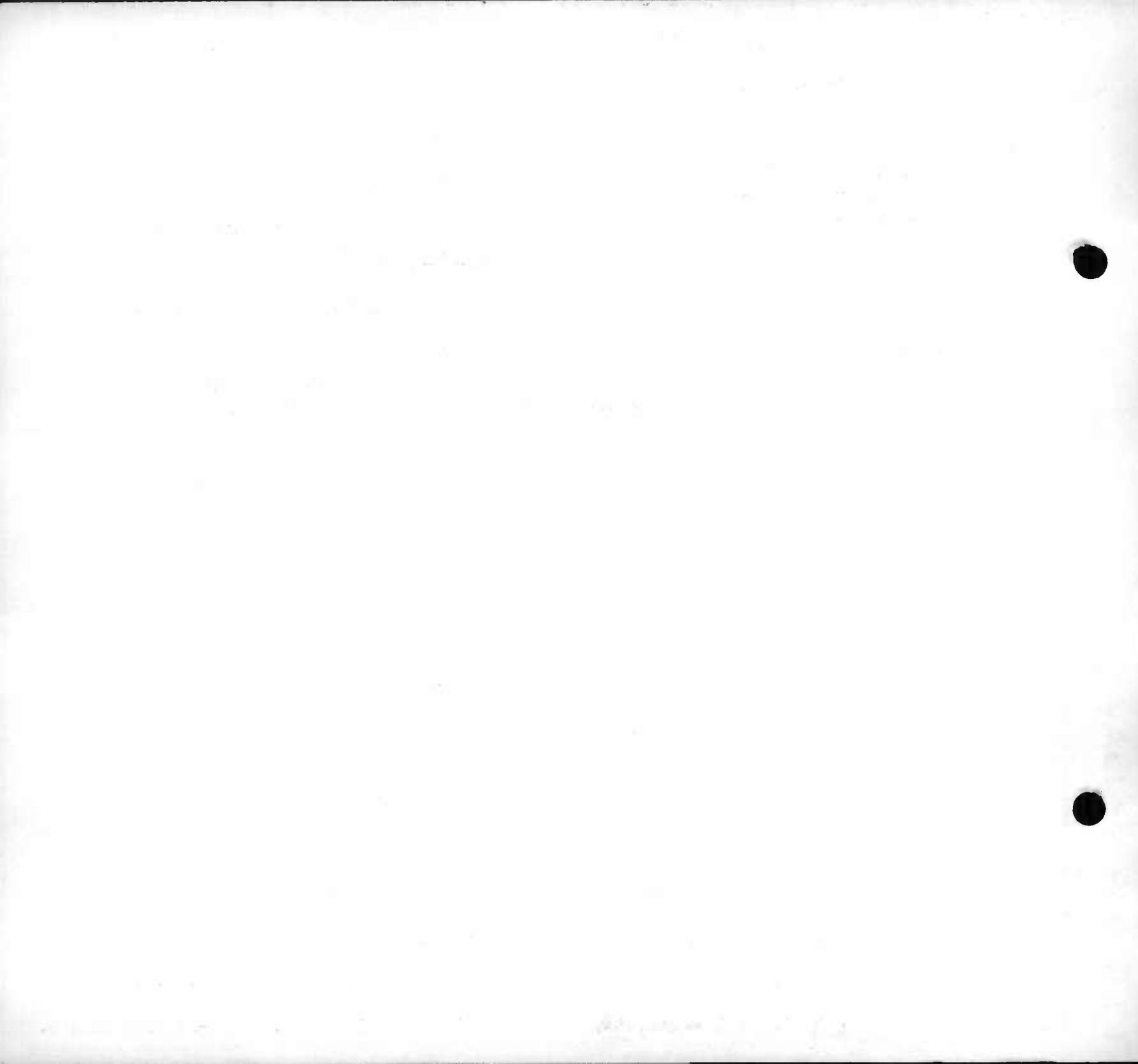
C-512 71 3912		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3912	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIE CORNBS		2. DATE AND HOUR OF DEATH 4-20-71 4:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2102		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		E. STREET AND NUMBER 1426 CARROLL ST.			
5. SEX MALE	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19 1900	9. AGE (in years last birthday) 70	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNK.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Julius Cornbs		14. MOTHER'S MAIDEN NAME Archie Boardley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK.		16. SOCIAL SECURITY NO. 212-14-0378		17. INFORMANT WALTER CORNBS (BROTHER) 3430 CARROLL ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4-20-71 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 HRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). COPD					
19A. DATE OF OPERATION 4-20-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CVA		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-19-71 19 71 to 4-20 19 71 that (I) (we) last saw the deceased alive on 4-20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jaime F. Casellas M.D.		23B. DATE SIGNED 4-20-71		23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/71		24C. NAME OF CEMETERY OR CREMATORY mt Calvary	
24D. LOCATION (City, town, or county) (State) Brooklyn md		25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Charles E. Jones Jr.	
25C. FUNERAL DIRECTOR Charles A. Rine		25D. ADDRESS 6614 Barvest			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3913	
S-246 71 3913		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Cora A. Sisler			2. DATE AND HOUR OF DEATH April 21, 1971 2:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY 101 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1014 South Elwood Avenue 21224		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1901	9. AGE (in years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry Sisler		
14. MOTHER'S MAIDEN NAME Sarah			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 220-10-4707A			17. INFORMANT 4940 Eastern Avenue ADDRESS BCH: Records Baltimore, Maryland 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 157.9 I Carcinoma of Stomach APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 30 1971 to April 19 1971 that (I) (we) last saw the deceased alive on April 19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas R. Griggs M.D.				23B. DATE SIGNED 4/21/71	
23C. PHYSICIAN'S NAME (Type) Thomas R. Griggs M.D.				23D. ADDRESS Baltimore City Hospitals 21224 4940 Eastern Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24, 1971		24C. NAME of CEMETERY or CREMATORY Maplewood Cemetery	
24D. LOCATION (City, town, or county) (State) Kingwood, West Virginia		25A. DATE REC'D BY HEALTH DEPT. APR 22 1971			
25B. NAME OF REGISTRAR Lilly & Zeiler Inc.		25C. FUNERAL DIRECTOR ADDRESS 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3914</u>	
1. NAME OF DECEASED (Type or Print) <u>HAROLD B. GIVANS</u>		2. DATE AND HOUR OF DEATH <u>4/17/71</u> <u>12:05</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1307</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>809 W. 36th. St.</u> <u>21211</u>			
5. SEX <u>M</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/99</u>		9. AGE (In years last birthday) <u>72</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MFG.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TOOL MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE B. GIVANS</u>			
14. MOTHER'S MAIDEN NAME <u>MARGARET TURNER</u>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW2</u>			
16. SOCIAL SECURITY NO. <u>213-10-3077</u>		17. INFORMANT <u>WIFE</u> ADDRESS			
18. CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>TRACHEAL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>RECURRENT EMPYSEMA PNEUMOTHORAX</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>EMPYSEMA</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>EMPYSEMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>1 DAY</u> <u>2 WK</u> <u>YEARS</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4/15/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>EMPYSEMA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> 19 <u>71</u> to <u>4/17</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sharon Satterfield M.D.</u>				23B. DATE SIGNED <u>4/17/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SHARON SATTERFIELD MD</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-21-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LAKEVIEW</u>	
24D. LOCATION (City, town, or county) (State) <u>Sykesville Bal Carroll Co Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u>			
25B. NAME OF REGISTRAR <u>Robert A. Vetter, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frank W. Satt</u> <u>814 W 36th St Balto Md</u> ADDRESS			



ACADEMIC (BIOGRAPHY)

RAI CENTRAL

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

1984-1985

1986-1987

1988-1989

1990-1991

1992-1993

1994-1995

1996-1997

1998-1999

2000-2001

2002-2003

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3916	
BIRTH NO. K-420 71 3916		CERTIFICATE OF DEATH			
1. NAME OF DECEASED <small>(Type or Print)</small> CAROLINE A. KOLACZ			2. DATE AND HOUR OF DEATH APRIL 20, 1971 1:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FULL NAME OF HOSPITAL OR INSTITUTION 00 2021 PORTUGAL ST. BALTO., MD. 21231 </div> <div style="width: 50%;"> 4. USUAL RESIDENCE <small>(Where deceased lived. If institution: residence before admission)</small> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. STATE MD. 21231 </div> <div style="width: 5%;"> 8. COUNTY 201 </div> </div> </div> </div>					
5. SEX Female			6. RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH NOV. 4, 1911		
10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> SEAMSTRESS			11. BIRTHPLACE <small>(State or foreign country)</small> SO. CAROLINA		
13. FATHER'S NAME JAN PERC			14. MOTHER'S MAIDEN NAME CATHERINE KULASZ		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> No			16. SOCIAL SECURITY NO. 215-05-2149		
17. INFORMANT BARBARA PALMER			ADDRESS 2021 PORTUGAL ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> 1347 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE acute cardiac dilatation		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CAUSE OF DEATH Coronary of the nature		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2dy		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? <small>(Yes or No)</small>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(notify medical examiner)</small>			21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		
21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>			21D. TIME OF INJURY <small>(Month) (Day) (Year) (Hour)</small>		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/17/71 19 to 4/20 19 71 , that (I) (we) last saw the deceased alive on 4/19 19 71 and that in (my) (our) opinion death occurred on the date 4/20 19 71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. C. Feldman			23B. DATE SIGNED 4/20/71		
23C. PHYSICIAN'S NAME <small>(Type)</small> S. C. Feldman			23D. ADDRESS 1440 E Balto		
24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> Burial			24B. DATE 4/22/71		
24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem.			24D. LOCATION <small>(City, town, or county)</small> Balto. Co. Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971			25B. NAME OF REGISTRAR J. B. B. B.		
25C. FUNERAL DIRECTOR W. Fialkowski			ADDRESS 2007 Eastern Ave.		

STATE OF MICHIGAN

IN SENATE

JANUARY 1901

1

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE

YEAR 1900

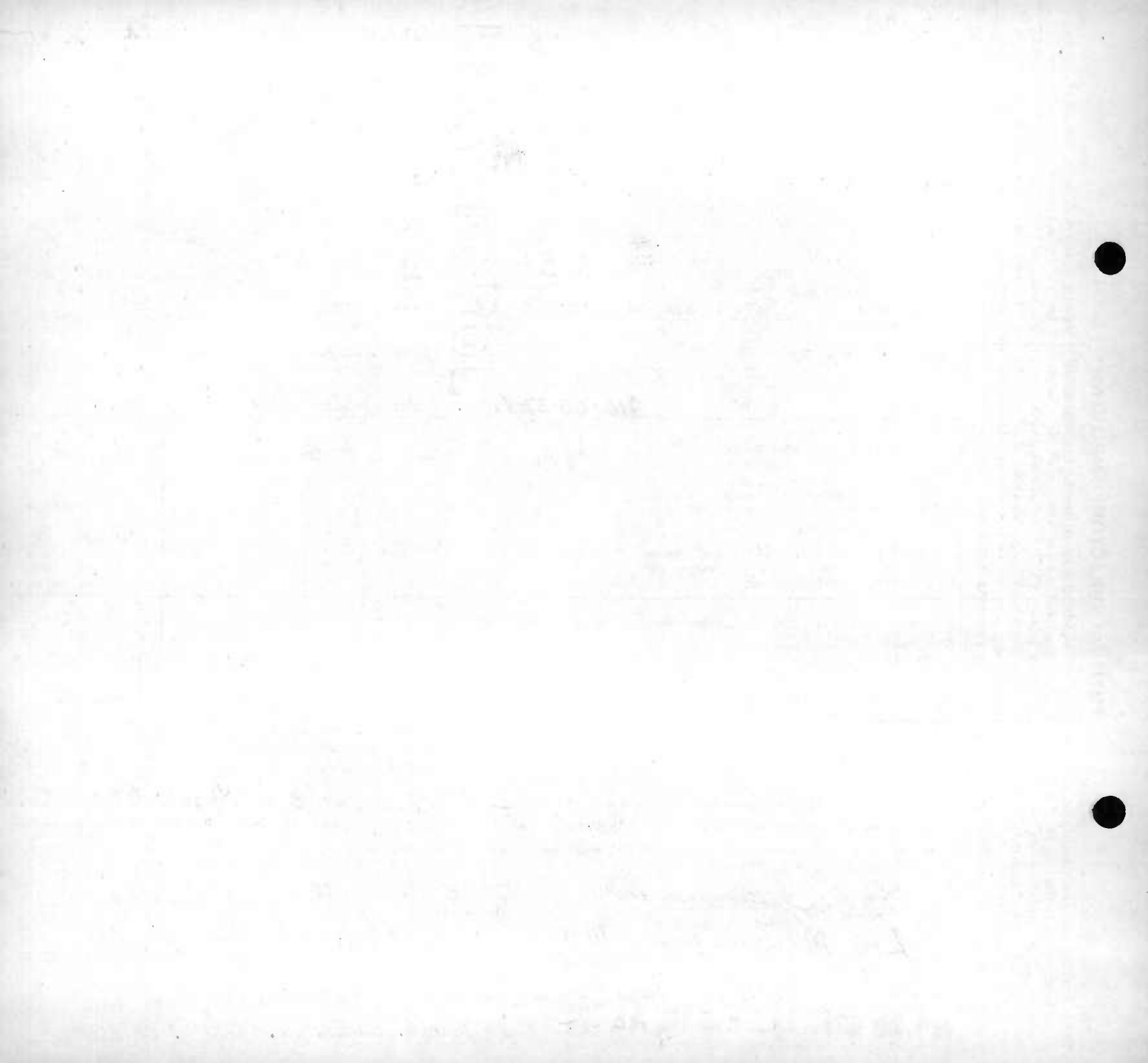
1901

1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>8671 3917</u>	
C-100 71 3917		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>William L. COFFEY</u>		2. DATE AND HOUR OF DEATH <u>4-19-71</u> <u>1 45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HARFORD GARDENS CONV. HOME</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTI</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3002 Frisby Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1912</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cableman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Western Electric Corp/ Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Coffey</u>		14. MOTHER'S MAIDEN NAME <u>Emma Kriening</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-3708</u>		17. INFORMANT <u>Mrs. Emma Coffey 3002 Frisby Street</u>	
18. <u>1912</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Malignant Tumor of Brain</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 16</u> 19 <u>70</u> to <u>April 19</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>April 1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ray M. Zimmerman M.D.</u>		23B. DATE SIGNED <u>4/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Ray M. Zimmerman M.D.</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/21/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mays Chapel Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. NAME OF REGISTRAR <u>John A. Moran, Inc.</u>		24F. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u>		25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

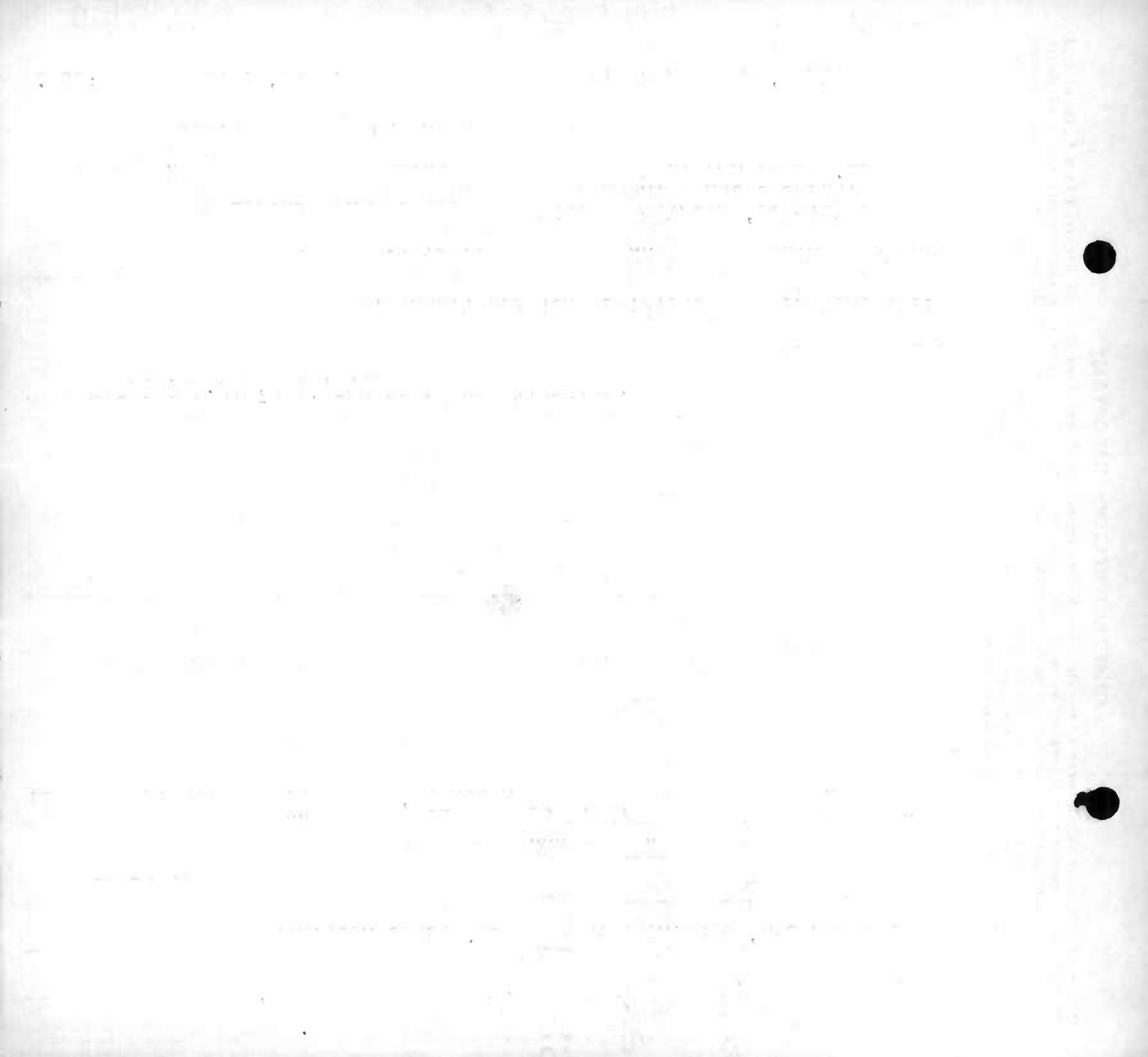
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
E-640		71 3918		71 3918		71 3918	
BIRTH NO.		71 3918		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		EARLE, ALMA R.		2. DATE AND HOUR OF DEATH		4.19.71 11.15 pm.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Lutheran Hosp. of Maryland				Md.		BALTO	
46				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER							
Box 185 Rt 15.							
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
F.	W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/7/04	67	HOUSE WIFE	Md.	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
ROSS		?		UNK.		212-24.9346	
17. INFORMANT				ADDRESS			
WINFIELD EARLE				A BOVE			
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						5 years.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
Uremia.							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
Carcinoma of the rectum.							
(C) Cutaneous Suro-rectal-vaginal fistula.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1966		Ca of rectum.		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3-26 1971 to 4/19 1971 that (I) (we) last saw the deceased alive on 4/19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
C. Gorkuba				4.19.71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. DATE OF DEATH			
C. Gorkuba		730, ASHBURTON St.		BALTO 21216			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		4/23/71		HOLLY HILL		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 22 1971		J. S. Connelley		J. S. Connelley		300 W. 1st St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3919	
BIRTH NO. B-420		71 3919		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) BALUCK, HELEN VERONICA			2. DATE AND HOUR OF DEATH APRIL 20, 1971 6:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND 21230 2403		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 904 COMPTON STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 04 91	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY CLEANING BUSINESS		11. BIRTHPLACE (State or foreign country) LITHUANIA
12. CITIZEN OF WHAT COUNTRY					
13. FATHER'S NAME JOHN Czelkevith			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 153185244		
			17. INFORMANT ADDRESS BALTIMORE, MD. 21229 ST AGNES HOSPITAL-WILKENS & CATON AVE.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Cardiac failure		
			(C) ? malig. neoplasia w/ metastasis		
19. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from MARCH 28, 19 71 to APRIL 20, 19 71 that (X) (we) last saw the deceased alive on APRIL 20, 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sabanayagam			23B. DATE SIGNED 04 20 71		
23C. PHYSICIAN'S NAME (Type) SABANAYAGAM, PONNAMPALAM			23D. ADDRESS ST. AGNES HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/23/71		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF HEALTH DEPT. OFFICIAL		25C. FUNERAL DIRECTOR ADDRESS McGully 1130 E. Fort Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>S-562 71 3920</i>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>71 3920</i>	
1. NAME OF DECEASED (Type or Print) <i>Baby Somers</i>				2. DATE AND HOUR OF DEATH <i>4/16/71 10:30 PM</i> <i>10:30 P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>md</i> B. COUNTY <i>2636</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>				C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>female</i> 6. RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>4-16-71</i>		9. AGE (In years lost birthday) <i>25</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>Bural Somers</i>				14. MOTHER'S MAIDEN NAME <i>Frieda Behrens</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>1310 Ballard Way</i>	
18. <i>75791</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Immaturity =</i> <i>Multiple congenital anomalies</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 22 min</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Apr 16 1971</i> to <i>Apr 16 1971</i> , that (I) (we) lost saw the deceased alive on <i>Apr 16 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Marston Alperung MD</i>				23B. DATE SIGNED <i>Apr 16, 1971</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/19/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Peter's Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Balto md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 22 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Thomas J. Kenney Jr</i>		ADDRESS <i>1600 70 1/104</i>	

ALBERT EINSTEIN

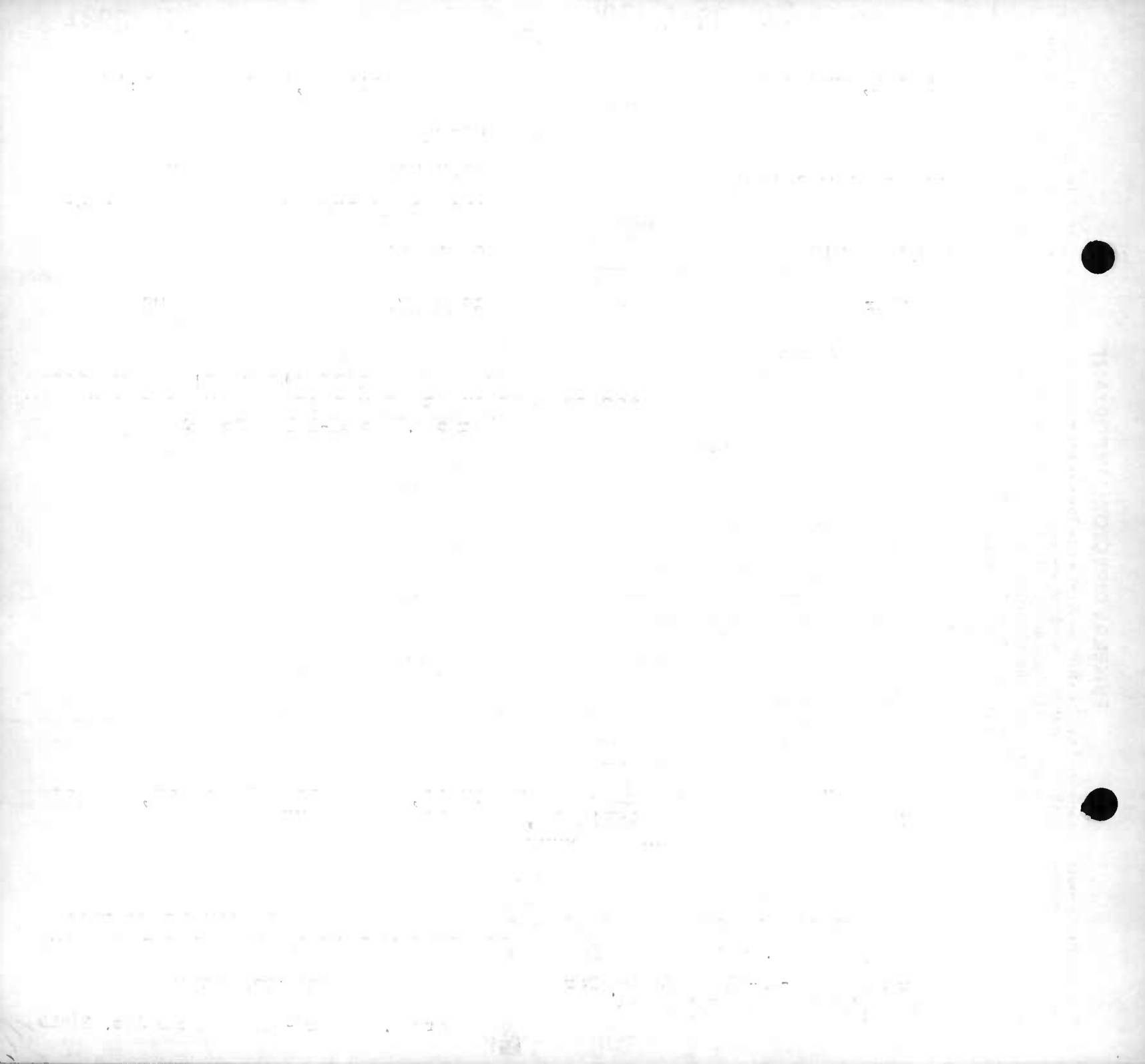
1905



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3921	
BIRTH NO. D-240 71 3921				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DIEGEL, THEODORE			2. DATE AND HOUR OF DEATH APRIL 20, 1971 2:45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1716 COLE STREET 21223		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09 12 01	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220 09 8960		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (Marie K. Diegel-1716 Cole St.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypotension and Shock. (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular disease (C) Constrictive Heart failure, Pulmonary Embolism APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two days 3 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from MARCH 13, 1971 to APRIL 20, 1971 that (X) (we) last saw the deceased alive on APRIL 20, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death.					
23A. SIGNATURE T. Mahmood M.D. DEGREE				23B. DATE SIGNED April 20	
23C. PHYSICIAN'S NAME (Type) TARIQ MAHMOOD				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-71		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Maryland		25A. DATE RECD. BY HEALTH DEPT. APR 22 1971			
25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave. 21229			



1

G-600 71 3922 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3922

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank Grau		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour Month Day Year Hour 4 16 71 6:45 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 16 71 6:45 p M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 831		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/11/13 1912		10. AGE (In years lost birthday) 59-58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		14B. KIND OF BUSINESS OR INDUSTRY Read Drug Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 216-07-9911	
18. INFORMANT Flora Grau		ADDRESS 2767 Chesterfield Ave., Balto Md. 21213	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR? 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/17/71 24A. BURIAL CREMATION, REMOVAL (Specify) burial 24B. DATE 4/20/71 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer 24D. LOCATION (City, town, or county) (State) Balto Md. 25A. DATE REC'D BY HEALTH DEPT APR 22 1971 25B. NAME OF REGISTRAR Robert E. Gable 25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. ADDRESS 3331 Brehms Lane, Balto Md. 21213			

VS 151-REV. 1/1/68

V.S. 153

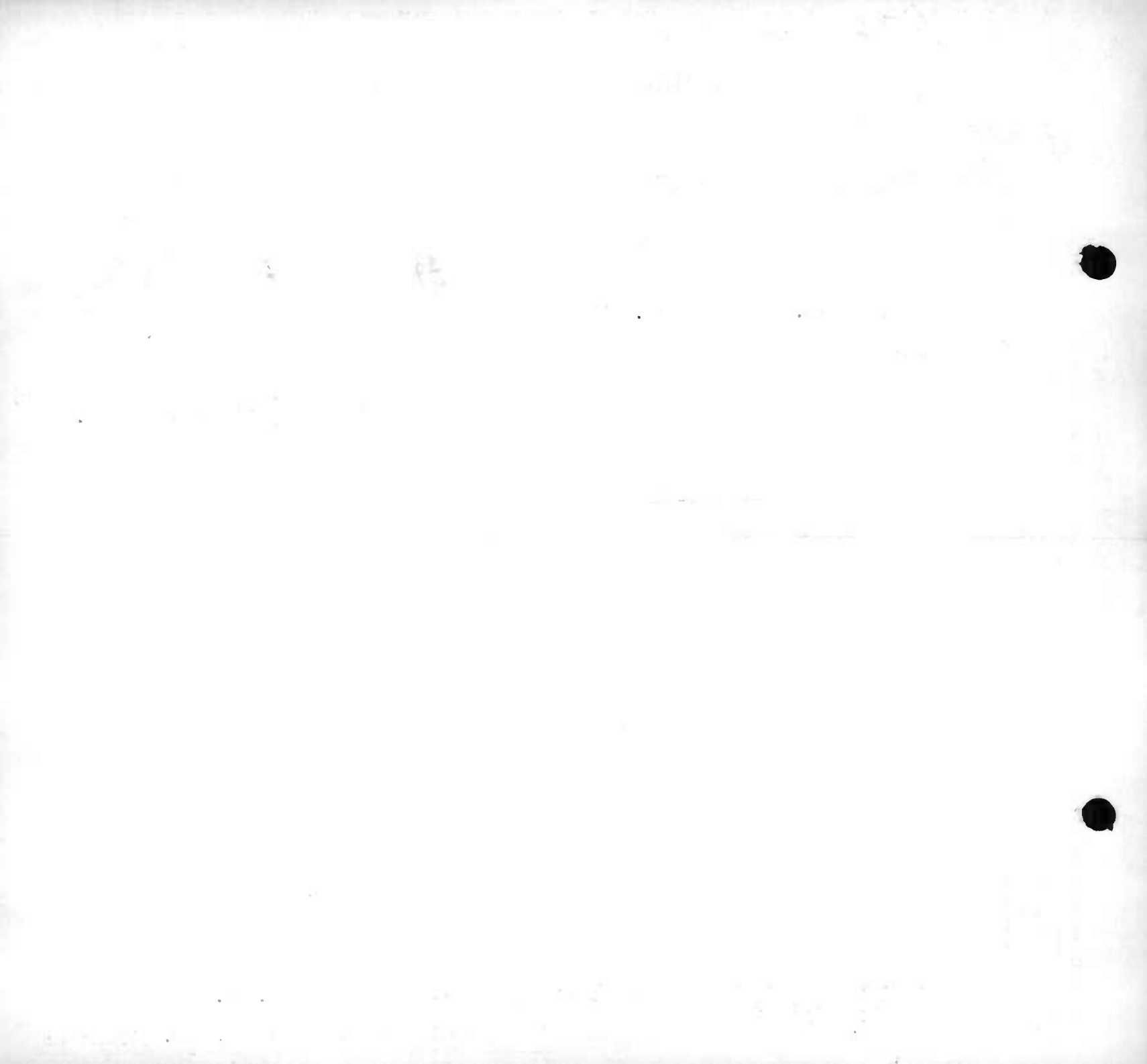
5-13-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

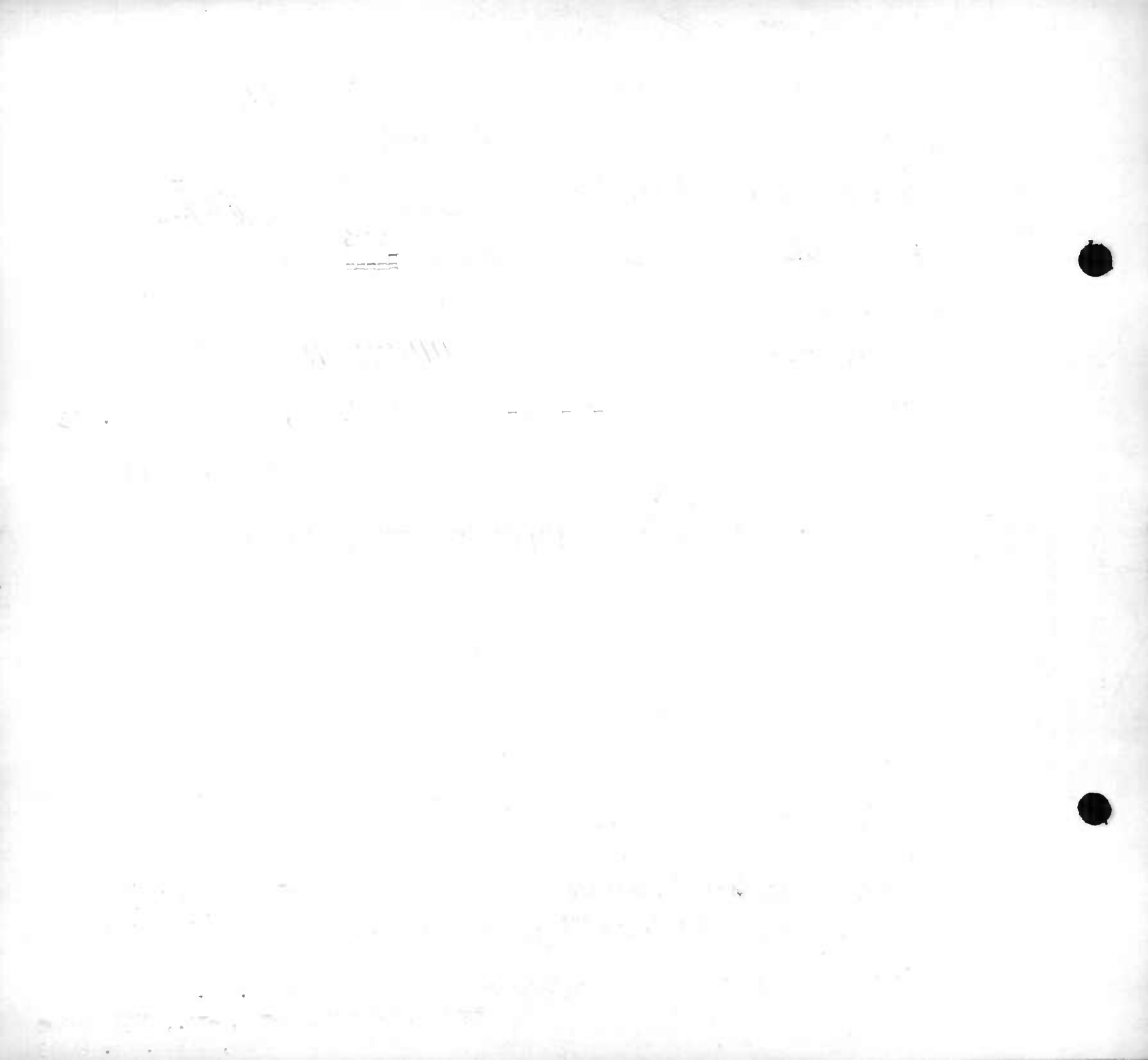
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. 71 3923					REG. NO. 71 3923				
1. NAME OF DECEASED (Type or Print) GEORGE HAMMER SCHMIDT					2. DATE AND HOUR OF DEATH 4/17/71 1:50 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital					A. STATE Maryland B. COUNTY 2643				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 3335 Clifton Av.				
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/178	9. AGE (In years last birthday) 92	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Dept.			10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Martin Hammerschmidt					14. MOTHER'S MAIDEN NAME Powers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 216-58-2221-55		17. INFORMANT Clara		ADDRESS Louis Hammerschmidt (son) 3335 Clifton Ave.		
18. 4/27/71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) respiratory arrest					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHF				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: CHF				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 4/19/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4/14/71 19 71 to 4/17 19 71 that (I) (we) last saw the deceased alive on 4/17 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE JACQUES K HOURY					23B. DATE SIGNED 4/17/71			23C. PHYSICIAN'S NAME (Type) JACQUES K HOURY	
23D. ADDRESS Union Memorial Hospital									
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 4/19/71		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971			25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.			ADDRESS 3331 Brehms Lane, Balto. Md. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____
C-500 71 3924				
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>May Cowan</u>		
2. DATE AND HOUR OF DEATH <u>April 17, 1971 9:45 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home & Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2702</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4561 Weitzel Ave</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1896</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Oscar Riley</u>		14. MOTHER'S MAIDEN NAME <u>Mable Kinsky</u> <u>Rosa Green</u> <u>Same</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-10-1904-0</u>		17. INFORMANT (son) <u>Walter McCormick, 3814 Elmora Ave. #13</u>
18. <u>43601</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension, Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) [Month] [Day] [Year] [Hour]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>March 29</u> 19 <u>71</u> to <u>April 17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Colando Mendoza</u>		23B. DATE SIGNED <u>4-17-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>COLANDO MENDOZA, M.D.</u>		23D. ADDRESS <u>100 N. Broadway, Balto. Md. 21223</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/21/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>
24D. LOCATION <u>Balto. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u>		25B. NAME OF REGISTRAR. <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21212</u>



1

T-650 71 3925 BALTIMORE CITY HEALTH DEPARTMENT

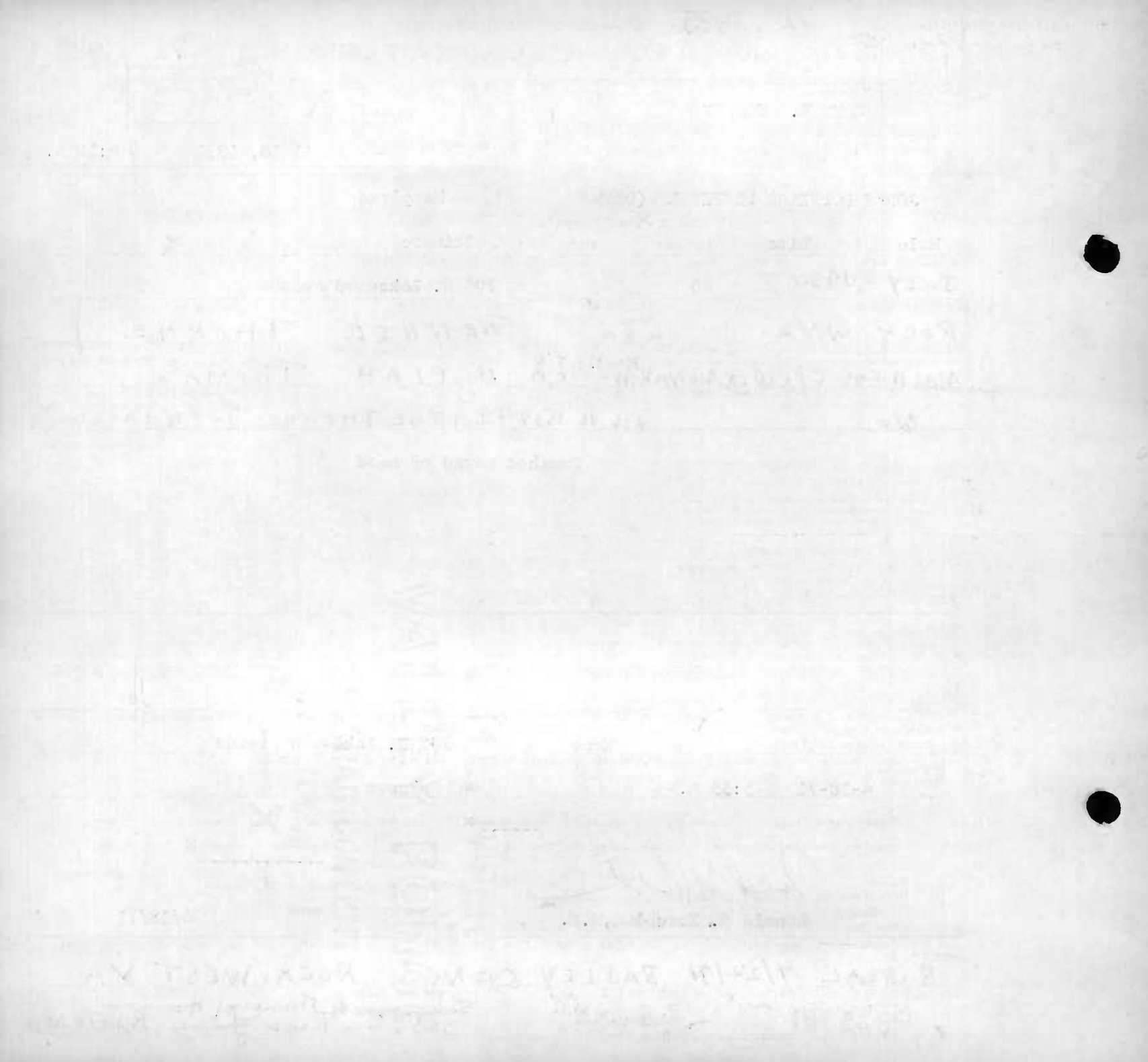
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3925

BIRTH NO.

1. NAME OF DECEASED (Type or Print) COY E. THORNE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 18, 1971 6:13 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH JULY 1, 1930		10. AGE (In years lost birthday) 40	
11. BIRTHPLACE (State or foreign country) Rock, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR MONARCH		14B. KIND OF BUSINESS OR INDUSTRY RUBBER CO	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 236-46-3538	
15. MOTHER'S MAIDEN NAME BUELAH THOMAS		18. INFORMANT PAULINE THORNE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTecedent CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2985 X	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME OF INJURY (APPROX.) 4-18-71 5:55 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 709 N. Lakewood Avenue		22F. HOW DID INJURY OCCUR? Unknown	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL-CREATION, REMOVAL (Specify) BURIAL		24B. DATE 4/22/71	
24C. NAME OF CEMETERY or CREMATORY BAILEY CEM.		24D. LOCATION (City, town, or county) (State) Rock, West Va.	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR Schmuck Funeral Home		ADDRESS 3331 Beechmont Lane, BALTO. MD.	

DATE SIGNED
4/18/71

VS 151-REV. 1/1/68

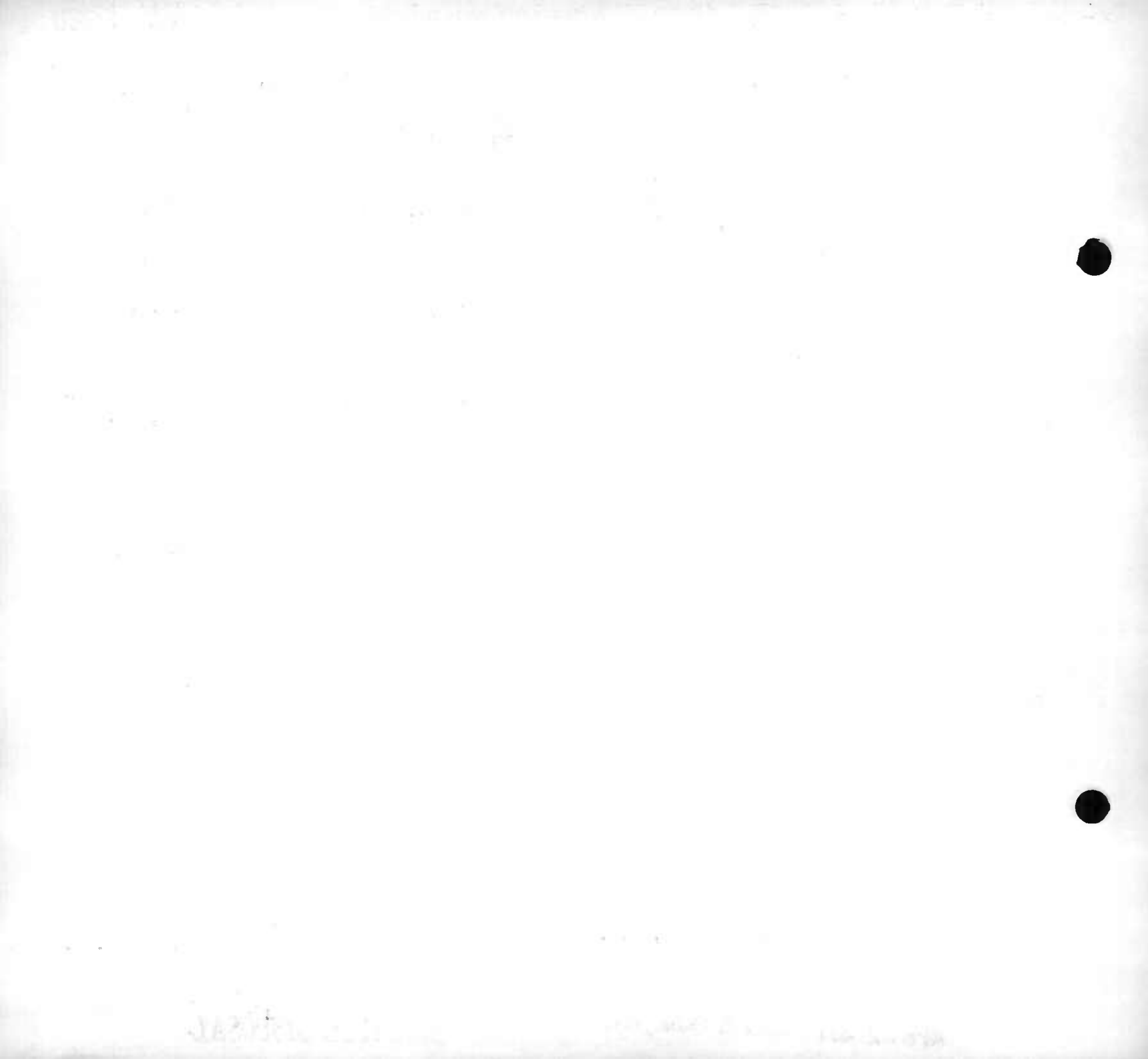


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
7-645-71 3926				71 3926	
BIRTH NO. 71-05595				1. NAME OF DECEASED	
Freeland, Terrie, Florence				2. DATE AND HOUR OF DEATH	
				April 12, 1971 1:40 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
BALTIMORE CITY HOSPITALS				Maryland	
4940 Eastern Avenue				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Baltimore, Maryland 21224				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.	
Female Negro				3-29-71 14	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
				Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Victor Thompson				Florence Freeland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
BCH RECORDS:				4940 Eastern Avenue	
				Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
? SEPSIS, RE				12 HRS	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) EXTREME PREMATURITY, DYSMATURITY DUE TO, OR AS A CONSEQUENCE OF:					
(C) ...					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				HYPERGLYCEMIA	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/9 to 4/12 1971 and that (I) (we) lost saw the deceased alive on 4/12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Peter R. Holbrook, M.D.				4/12/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Peter R. Holbrook, M.D.				Baltimore City Hospitals	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Cremation				4-14-71	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Baltimore City Hospitals				Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
APR 22 1971				Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR				ADDRESS	

HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]	
CERTIFICATE OF DEATH					
BIRTH NO. J-250 71 3927		DATE AND HOUR OF DEATH 4-14-71 1:35 P.M.			
1. NAME OF DECEASED (Type or Print) Baby Boy Jackson		2. DATE AND HOUR OF DEATH 4-14-71 1:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4940 Eastern Ave. Balto. Md. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY [REDACTED]			
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4-12-71	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years last birthday) NB		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Laura Alice Jackson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT BCH: Records		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/12 19 71 to 4/14 19 71 that (1) (we) last saw the deceased alive on 4/14 19 71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter R. Holbrook M.D.		23B. DATE SIGNED 4/14/71		23C. PHYSICIAN'S NAME (Type) Peter R. Holbrook M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-15-71		24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1977		25B. NAME OF REGISTRAR Robert E. Bailey R.D.		25C. FUNERAL HOME	
HOSPITAL DISPOSAL					

847 White lock st.

BIRTH NO.		71 3928		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 3928	
1. NAME OF DECEASED (Type or Print) Ernest WARE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour		3. DATE PRONOUNCED DEAD Month Day Year Hour April 16, 1971 12:25 P.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Rear- 509 Roberts Street				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 701			
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-3-97		10. AGE (In years last birthday) 73		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Jacob Ware	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				14B. KIND OF BUSINESS OR INDUSTRY longshoreman		15. MOTHER'S MAIDEN NAME Mary Gordon			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				17. SOCIAL SECURITY NO. 215-07-5546		18. INFORMANT Margaret Mitchell		ADDRESS same	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes (Head-Only)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/71				ACTUAL SIGNATURE Ronald N. Kornblum, M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street			

1982

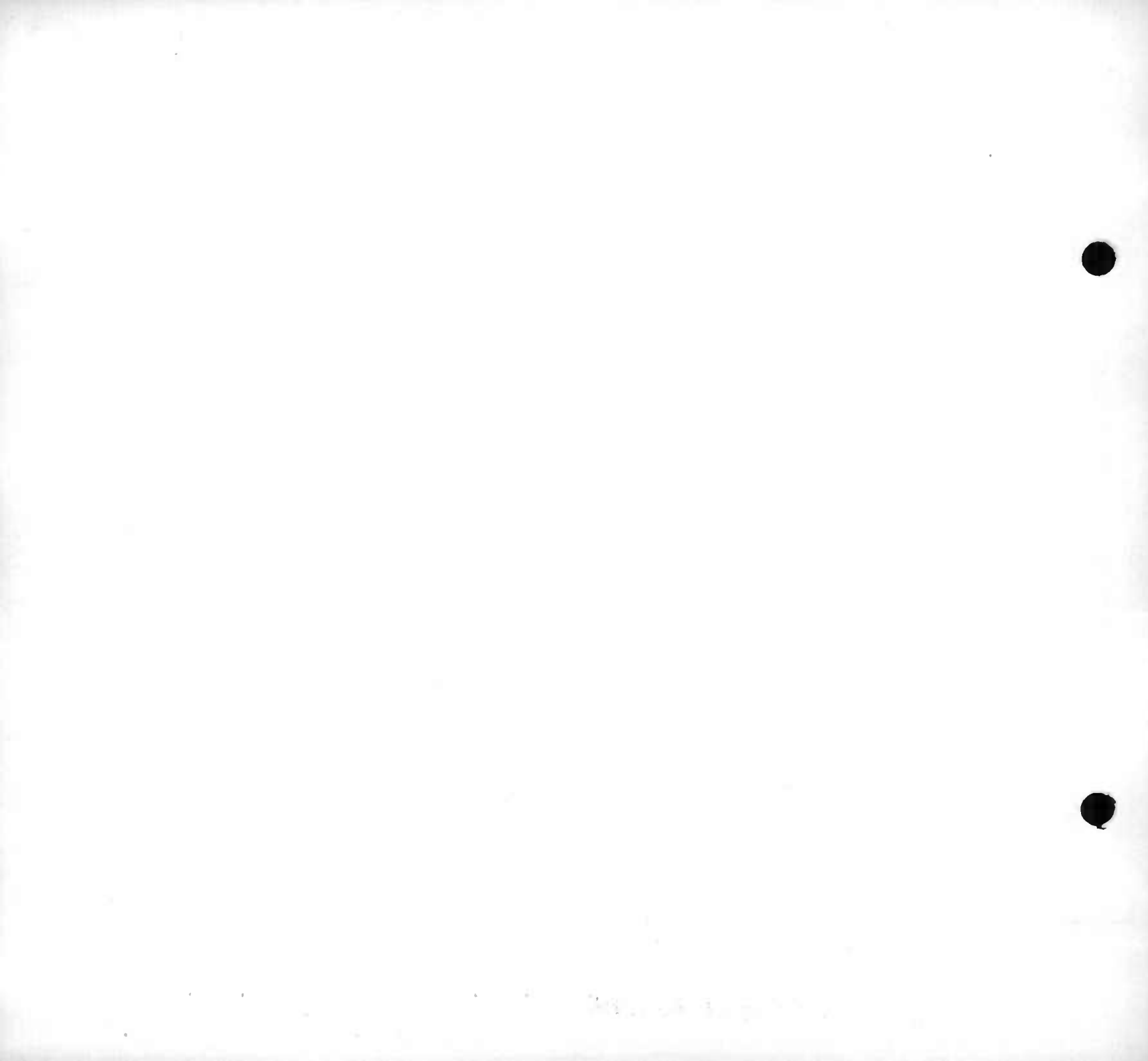
10

MAILING PHOTO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3929	
C-416 71 3929				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELLA REGINA CLIFFORD (Bryant)		2. DATE AND HOUR OF DEATH 4/20/71 6:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL 38			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1602		
			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1019 N. CALHOUN ST.		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/1/02	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT HILL		14. MOTHER'S MAIDEN NAME AMELIA GLEVES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Nelson Clifford CHART (P.)	
ADDRESS same 3800					
18. 150X I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE EMPYEMA + PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: PROBABLE				2 WK	
(B) RADIATION NECROSIS TRACHEA DUE TO, OR AS A CONSEQUENCE OF:				1 MO.	
(C) CARCINOMA ESOPHAGUS				1 YR	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3-18-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA ESOPHAGUS		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month (Day) 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4/16 19 71 to 4/20 19 71 that (I) (we) last saw the deceased alive on 4/20 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sharon Satterfield MD				23B. DATE SIGNED 4/20/71	
23C. PHYSICIAN'S NAME (Type) SHARON SATTERFIELD M.D.				23D. ADDRESS UNIVERSITY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-24-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert J. Taylor, M.D.		25C. FUNERAL DIRECTOR V. Bailey	
ADDRESS 1348 Calhoun St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 71 3930		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3930	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Barnes, Helen		2. DATE AND HOUR OF DEATH April 20, 71 6: 25 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1901		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1610 W. Saratoga Street 21223	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-10-22	9. AGE (In years last birthday) 48	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Hardey, Isaaiah		14. MOTHER'S MAIDEN NAME Hardey Mary Hardey		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212200741		17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: shock (B) chronic UREMIA DUE TO, OR AS A CONSEQUENCE OF: (C) Subarachnoid hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr several years Mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/12 1971 to 4/20 1971 that (I) (we) last saw the deceased alive on 4/20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Burton, M.D.		23B. DATE SIGNED 20 Apr 71		23C. PHYSICIAN'S NAME (Type) John Burton, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR V. Bailey Kelson F.H. 1348 Calhoun Street	
25D. LOCATION (City, town, or county) (State) Baltimore, Md.		25E. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 21224			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				71 3931		71 3931	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Altonson Chambers</u>				2. DATE AND HOUR OF DEATH <u>4-19-71</u> <u>8:16</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>603</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>				6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6/22/22</u>				9. AGE (in years last birthday) <u>48</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipbuilder</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Beth Shipyard</u>			
11. BIRTHPLACE (State or foreign country) <u>Lynchburg, Va.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Duke Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Hattie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>224 14 4428</u>		17. INFORMANT <u>Sarah Early 206 Center Ave</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC CVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>S/P STROKE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3</u> <u>19 71</u> to <u>4-5</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>4-5</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>B. L. Portnoy MD</u>				23B. DATE SIGNED <u>4-19</u>		23C. PHYSICIAN'S NAME (Type) <u>B. L. PORTNOY</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/24/71</u>		24C. NAME of CEMETERY or CREMATORY <u>mt. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u>			
25B. NAME OF REGISTRAR <u>Reese, J. E.</u>				25C. FUNERAL DIRECTOR <u>Joseph G. Lock</u>			
25D. ADDRESS <u>1304 N. Central Ave</u>							

100-100000

RECEIVED

X

RECEIVED

JOHN HOPKINS HOSPITAL

3333 GREEN STREET

6/22/55

MALE NEGRO

SSA J. H. WASH

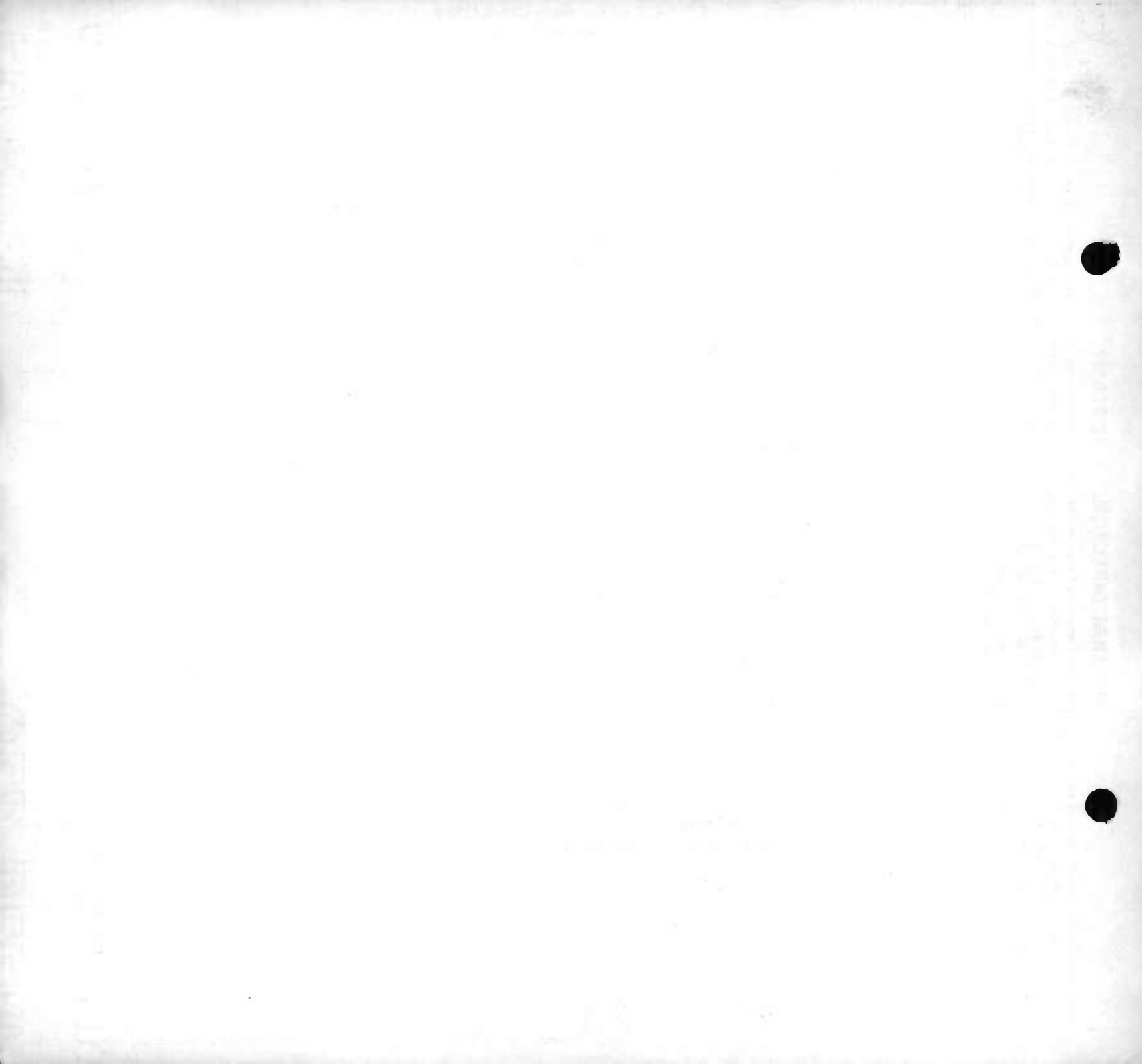
100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 3932

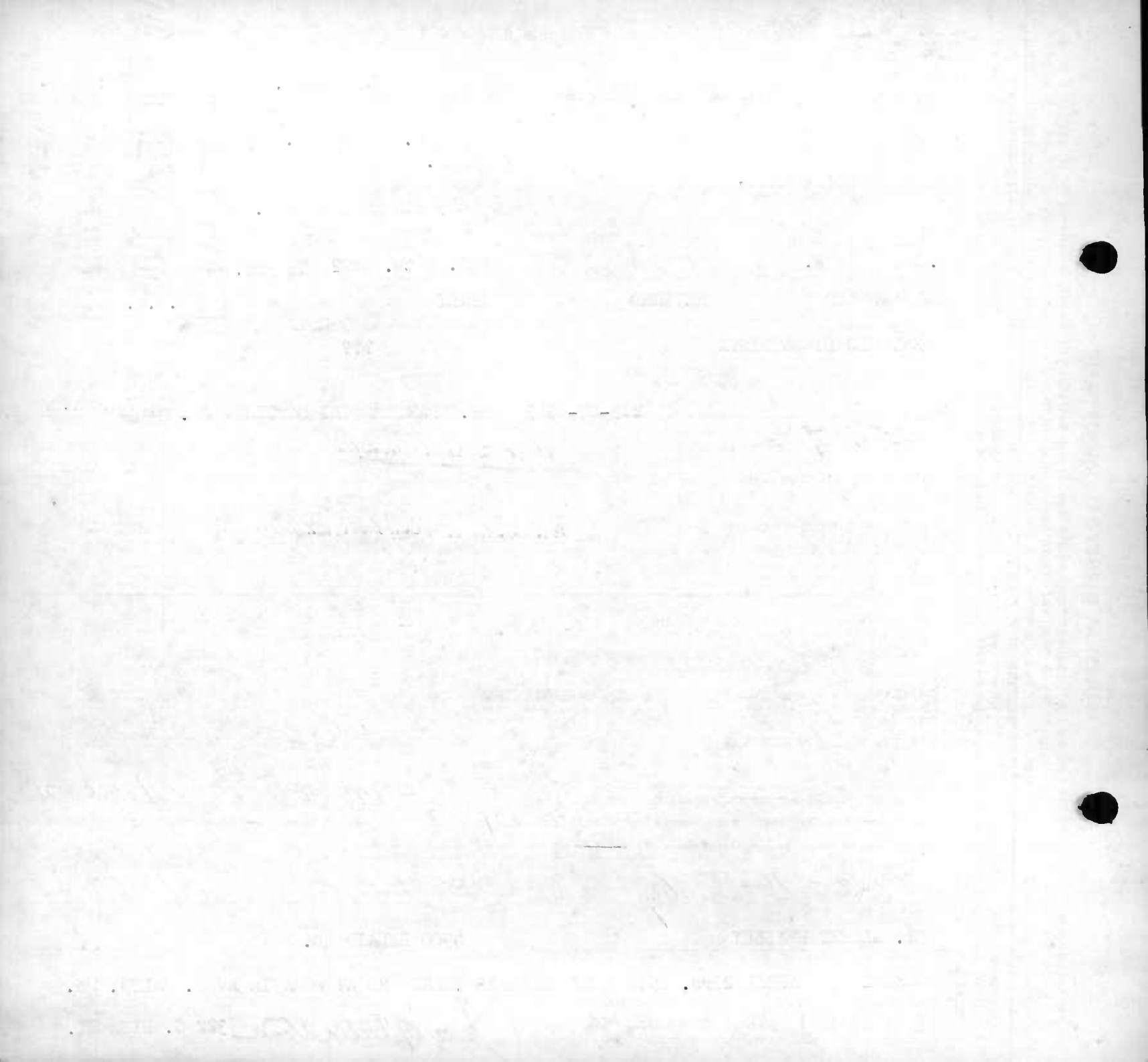
BIRTH NO. 3932		REG. NO. 3932	
1. NAME OF DECEASED (Type or Print) Tarasovich, John		2. DATE AND HOUR OF DEATH 4/14/71 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2631	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44 Balto.		C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-94 9. AGE (In years last birthday) 76 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russian	
13. FATHER'S NAME Pedor Tarasewich (D)		14. MOTHER'S MAIDEN NAME Ann Tarasevich (D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT wife Sarah Tarasevich		ADDRESS	
18. 4-36-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) respiratory failure pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C)	
19. DATE OF OPERATION 4/10 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/10 19 71 to 4/13 19 71 that (I) (we) last saw the deceased alive on 4/12 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Charles F. Fazekas		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) FAZEKAS MD.		23D. ADDRESS 2114 H.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR R. E. Farley, M.D.	
25C. FUNERAL DIRECTOR Dallas D. Dwyer (Richard B. Dwyer)		25D. ADDRESS 5 High St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burn; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3933</u>	
BIRTH NO. <u>71 3933</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>FRANCESCO DI BATTISTA</u>		2. DATE AND HOUR OF DEATH <u>APRIL 20th. 1971</u> <u>12:50 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 GOULD NURSING HOME</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>MALE</u> 6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 16th. 1892</u> 9. AGE (In years lost birthday) <u>79 yrs.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEELWORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
13. FATHER'S NAME <u>ANTONIO DI BATTISTA</u>		14. MOTHER'S MAIDEN NAME <u>???</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-07-1943</u>		17. INFORMANT <u>MR. FRANCESCO DI BATTISTA JR.</u>	
18. <u>4-7-71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Acute Cardiovascular Accident</i>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Generalized Arteriosclerosis</u>			
		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?		21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?	
22. I certify that (I) (was not) attended the deceased from <u>4/19/71</u> to <u>4/19/71</u> that (I) (was) last saw the deceased alive on <u>4/19/71</u> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B Bradley</u>		23B. DATE SIGNED <u>4/21/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. ALBERT BRADLEY</u>	
23D. ADDRESS <u>4900 BELAIR RD.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>APRIL 23rd. 1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>322 S. HIGH ST.</u>	



1

K-643

71 3934 BALTIMORE CITY HEALTH DEPARTMENT

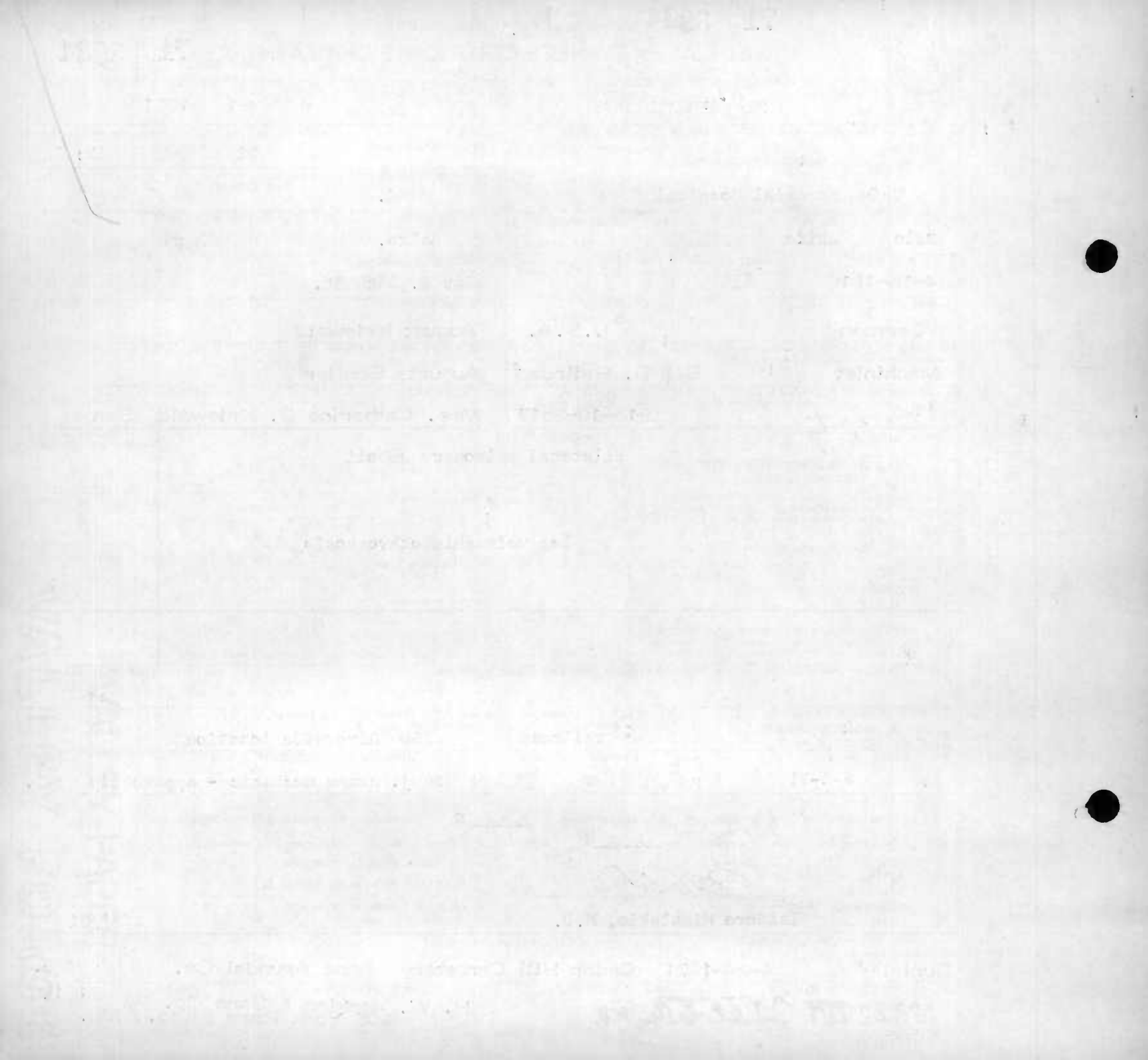
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3934

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRED KRIEWALD		2. DATE OF DEATH Known <input type="checkbox"/> Month 4 Day 21 Year 1971 Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 21 Year 1971 Hour 12:47a M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 903			
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 4-15-1910		10. AGE (In years last birthday) 61	E. STREET AND NUMBER 749 E. 36th St.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME August Kriewald
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		14B. KIND OF BUSINESS OR INDUSTRY B & O. Railroad	15. MOTHER'S MAIDEN NAME Augusta Schlier
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-10-3517	18. INFORMANT Mrs. Catherine D. Kriewald
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E928 X Bilateral pulmonary emboli		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. leg vein phlebothrombosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) railroad	
22D. TIME OF INJURY (APPROX.) 4-5-71 1 p m.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) B&O Riverside location 2402		22F. HOW DID INJURY OCCUR? Subj. crane mechanic - apparently fell.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-1971	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Road Balto., Md.	

DATE SIGNED 4/21/71

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
S-123 71 3935		71 3935	
BIRTH NO.		71 3935	
1. NAME OF DECEASED (Type or Print) SHAPCOTT, Mrs Gertrude A.		2. DATE AND HOUR OF DEATH 4/21/71 8:45 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2712	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 416 Hollen Rd.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-84
		9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Bearton Wilhelm		14. MOTHER'S MAIDEN NAME Jennie M. Cumbler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. WA 390745	17. INFORMANT Mrs. Dorothy S. Oest
ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHF - 2° ASCVD. (B) DUE TO, OR AS A CONSEQUENCE OF: Ca - uterus by hx. (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indefinitely medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4-08 19 71 to 4/21 19 71 that (1) (we) last saw the deceased alive on 4/21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>M. Jenkins</i>		23B. DATE SIGNED 4/21/71	
23C. PHYSICIAN'S NAME (Type) DR. NAME J. W. JENKINS		23D. ADDRESS 607 Md. General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-71	
24C. NAME OF CEMETERY OR CREMATORY New Freedom Cem.		24D. LOCATION (City, town, or county) (State) New Freedom Cem. Pa.	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.		ADDRESS 4905 York Rd. Baltimore, Md. 21212	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3936

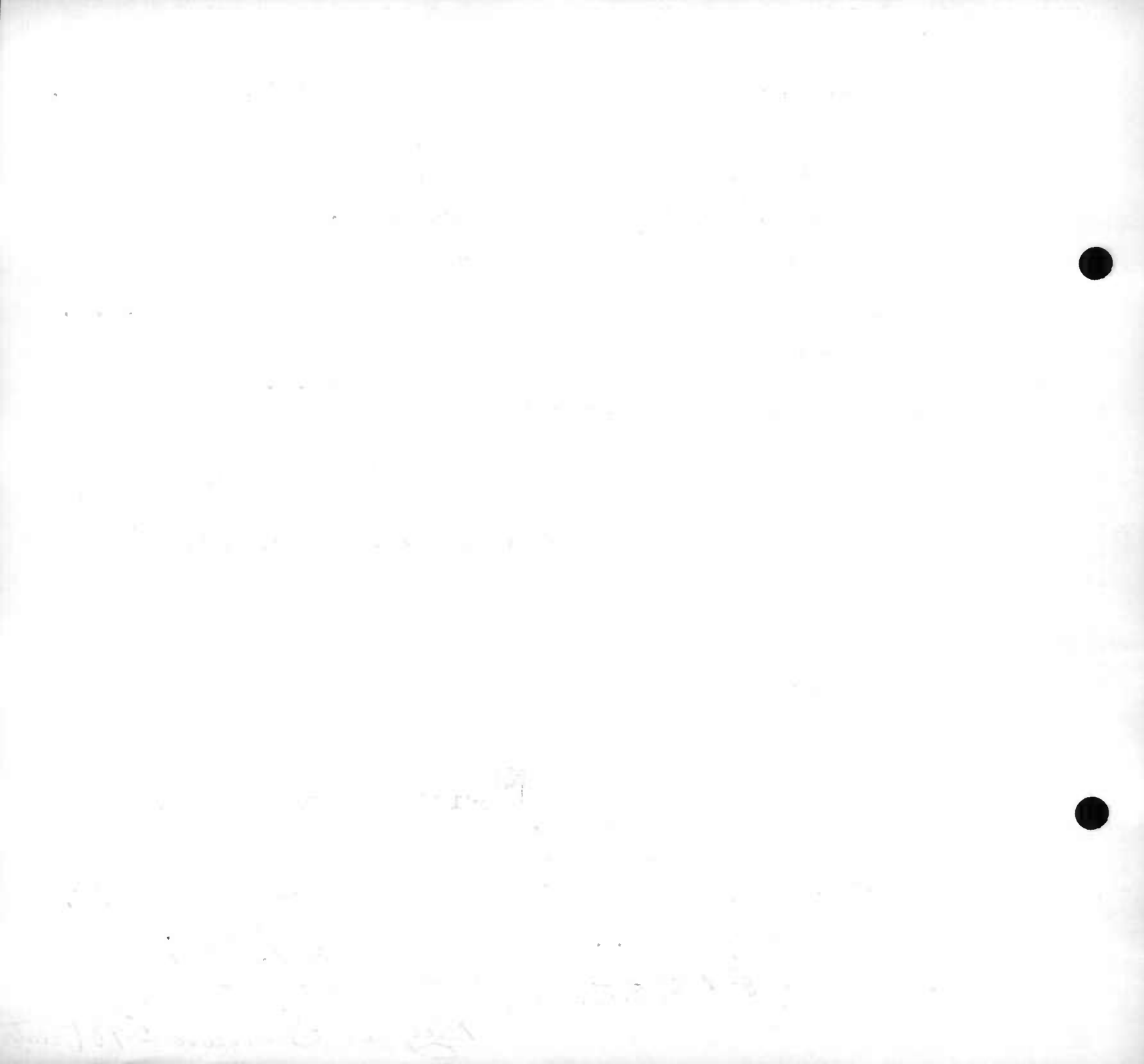
BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Page		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 12 Year 71 Hour 8:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 12 Year 71 Hour 8:30 a.m.	
6. SEX Male		7. RACE Col	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7-8-19		10. AGE (In years last birthday) 52	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Lillie Hall		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Lillie Reynolds	
19. CAUSE OF DEATH Acute bronchopneumonia		ADDRESS 2035 E Larnal St	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/12/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-71	
24C. NAME OF CEMETERY or CREMATORY MT Calvary Em A.C. Co		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 517 E. Preston St	

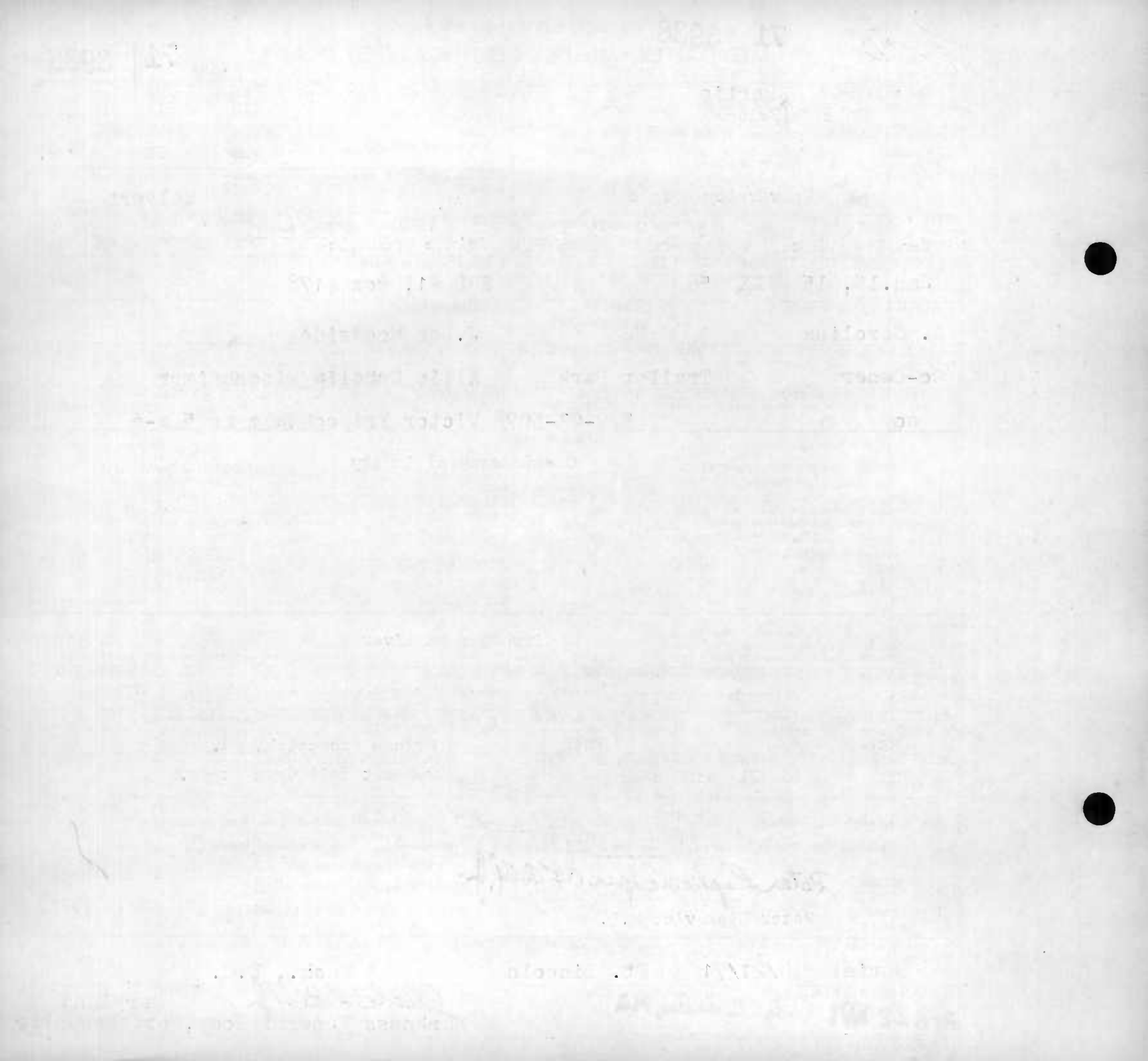
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 3937</u>	
7-540 BIRTH NO. <u>71 3937</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>FENNELL, LEWIS</u>		2. DATE AND HOUR OF DEATH <u>April 18, 1971</u> <u>4:10 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>907</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2609 Robb St.</u>	
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Handler</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>	9. AGE (In years last birthday) <u>52</u>
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ernest Fennell</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Tolliver</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>1-21-44 to 2-19-46</u>		16. SOCIAL SECURITY NO. <u>411-01-6928</u>	
17. INFORMANT <u>Records V. A. Hospital</u>		ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Maryland</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>12/23/70</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of lung</u> 20A. AUTOPSY? (Yes or No) <u>yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>April 15, 1971</u> to <u>April 18, 1971</u> that <u>X</u> (we) last saw the deceased alive on <u>April 18, 1971</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Robert Daryl Fisher, M.D.</u> 23B. DATE SIGNED <u>4/19/71</u> 23C. PHYSICIAN'S NAME (Type) <u>ROBERT DARYL FISHER, M.D.</u> 23D. ADDRESS <u>3900 Loch Raven Blvd. Baltimore, Md 21218</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>4/23-71</u> 24C. NAME of CEMETERY or CREMATORY <u>Gettysburg National Cemetery</u> 24D. LOCATION (City, town, or country) (State) <u>Prima</u> 25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u> 25C. FUNERAL DIRECTOR <u>Rayner Sanders</u> ADDRESS <u>217 E. Preston</u>			



Baltimore City Health Department									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 71-3938									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Bertie Ophelia Frisco					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 4 Day 18 Year 71 Hour 10:00 a.m.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					3. DATE PRONOUNCED DEAD Month 4 Day 18 Year 71 Hour 10:00 a.m.				
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital					5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Calvert 5400				
6. SEX female		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Prince Frederick		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Jan. 15, 1956		10. AGE (In years last birthday) 56		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME J. Lee Woodside	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-owner		14B. KIND OF BUSINESS OR INDUSTRY Trailer Park		15. MOTHER'S MAIDEN NAME Allie Ophelia Misenheimer					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 579-03-5078		18. INFORMANT Victor Frisco Same as 5 a-e		ADDRESS			
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Craniocerebral injury									
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cirrhosis of liver									
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Prince Frederick, Md. 5400					
22D. TIME OF INJURY (APPROX.) 4 15 71 8:00 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject fell down steps.					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE: Peter Lipkovic per C.F. Bell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/19/71			
EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/71		24C. NAME OF CEMETERY or CREMATORY Ft. Lincoln		24D. LOCATION (City, town, or county) (State) Wash., D.C.			
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Harkness Funeral Home, Port Republic		ADDRESS Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

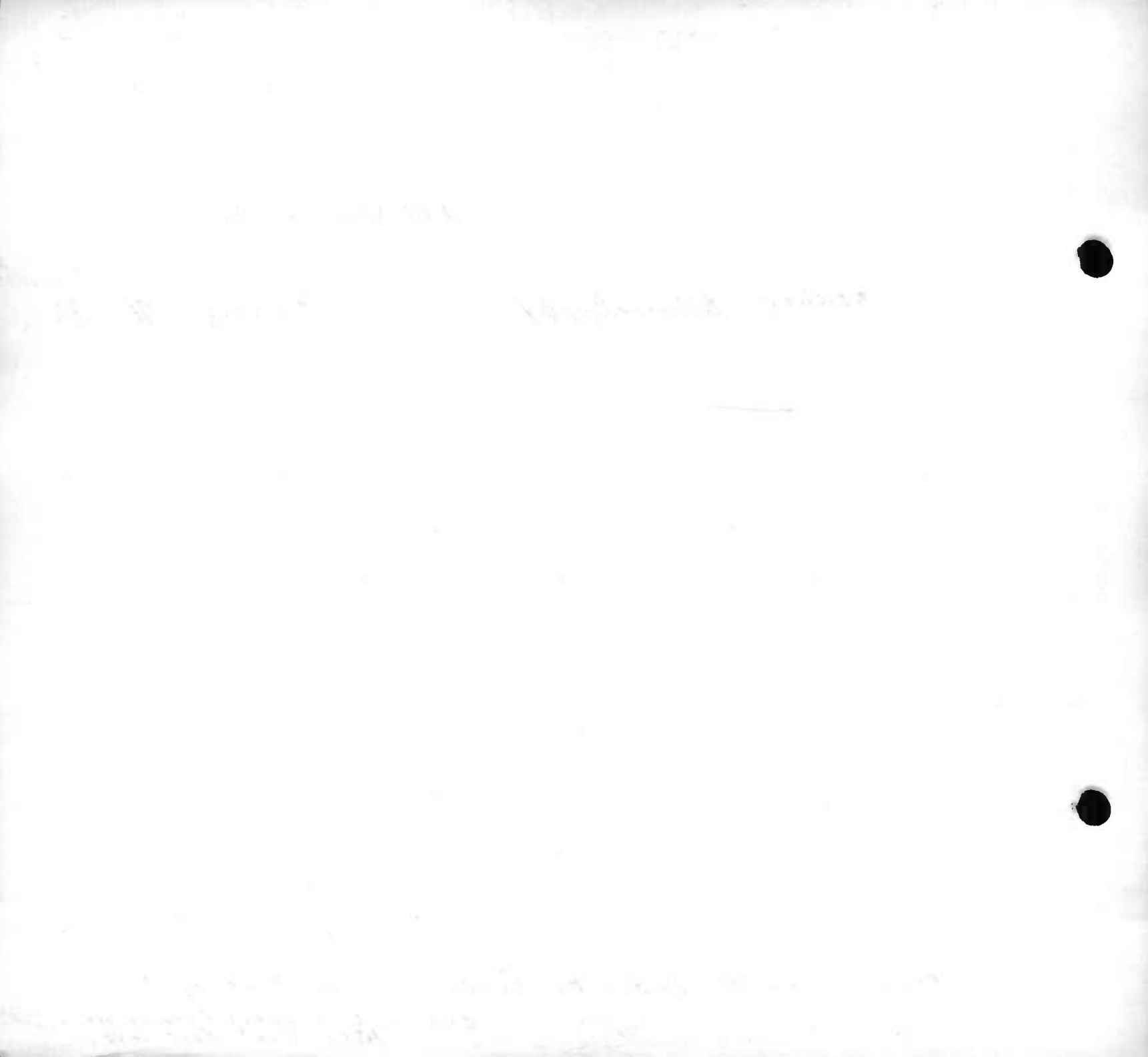
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3939	
BIRTH NO. P-230 71 3939		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Sadiq SARAH Piggott		2. DATE AND HOUR OF DEATH 4/21/71 10³⁰ A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington Nat'l H 4-27-71 607 Pennsylvania Ave		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Wash. C. CITY OR TOWN Hagerstown, Md D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2026 Virginia Ave.	
5. SEX F.	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 7.		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 94
11. BIRTHPLACE (State or foreign country) Berkley Cty., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Lloyd		14. MOTHER'S MAIDEN NAME Martha Beck	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no --		16. SOCIAL SECURITY NO. 216-54-8017 JI	
17. INFORMANT 138 W. Wash. St. Hagerstown, Md Chas. Harold H. Hoffman, Atty.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF RECTUM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/29/69	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last INTRAABDOMINAL METASTASIS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RECTAL CANCER	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1-23-1970 to 4-21-1971 and that (2) (we) lost saw the deceased alive on 4-19-1971 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Richard F. Tyson M.D.		23B. DATE SIGNED 4-21-71	
23C. PHYSICIAN'S NAME (Type) Dr. Richard F. Tyson M.D.		23D. ADDRESS 936 West North Ave., Balto. Md. 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71	
24C. NAME OF CEMETERY OR CREMATORY Edgehill Cemetery		24D. LOCATION (City, town, or county) (State) Charles Town, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. APR 22 1971		25B. NAME OF REGISTRAR Robert E. Talley, MD	
25C. FUNERAL DIRECTOR Hagerstown, Md.		ADDRESS A. K. Coffman Funeral Home, Inc.	

Letter from Funeral Director
4-27-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

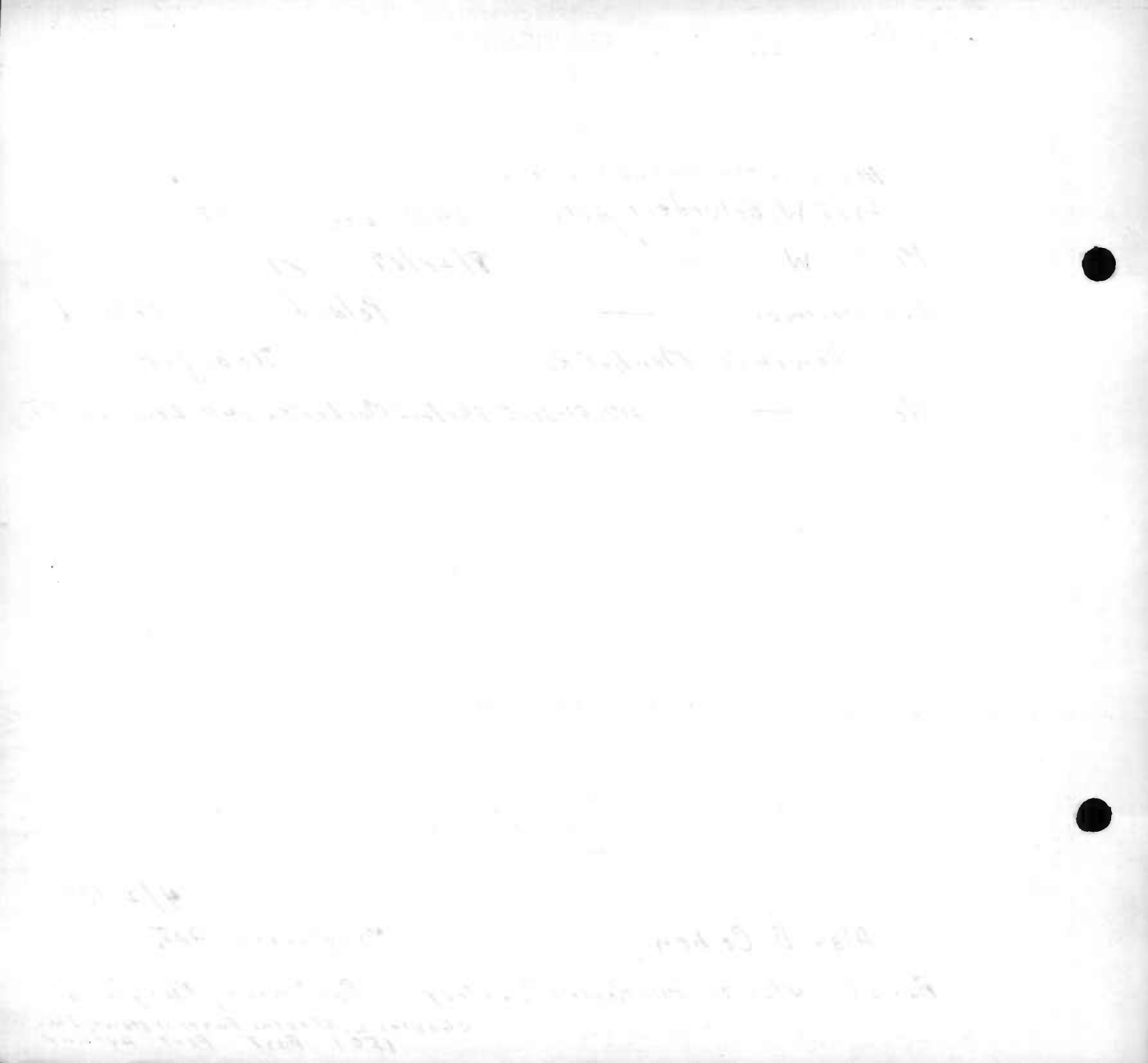
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. 71 3940											
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. P-400</p> <p>1. NAME OF DECEASED (Type or Print) Margaret Poole</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 4-17-71 10:30 A.M.</p> </div> </div>											
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles General Hospital</p>						<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2201</p> <p>C. CITY OR TOWN Baltimore</p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 214 Warren Ave.</p>					
<p>5. SEX F</p>		<p>6. RACE W</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 10-14-02</p>		<p>9. AGE (In years last birthday) 68</p>		<p>10. Under 1 Yr. Months: Days: Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>						<p>10B. KIND OF BUSINESS OR INDUSTRY Baltimore Paper Box</p>					
<p>11. BIRTHPLACE (State or foreign country) Baltimore, Maryland</p>						<p>12. CITIZEN OF WHAT COUNTRY? U. S. P.</p>					
<p>13. FATHER'S NAME Edward Seward</p>						<p>14. MOTHER'S MAIDEN NAME Probach</p>					
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>						<p>16. SOCIAL SECURITY NO. 214-24-0546</p>					
<p>17. INFORMANT Chant</p> <p>ADDRESS</p>											
<p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 15%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure 3 weeks</p> <p>(B) Arteriosclerotic Heart Disease unknown</p> <p>(C) Hypothyroidism unknown</p>											
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none.</p>											
<p>19A. DATE OF OPERATION None.</p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>				<p>20A. AUTOPSY? (Yes or No) No.</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No.</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> NO</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None</p>				<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None</p>				<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>				<p>21F. HOW DID INJURY OCCUR? None.</p>			
<p>22. I certify that (this hospital) attended the deceased from 4/8/71 19 to 4/17/71 19 that (I) (we) last saw the deceased alive on 4/17/71 19 and that in (my) (our) opinion death occurred on the date 4/17/71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
<p>23A. SIGNATURE Richard L. Heppner M.D.</p>								<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>		<p>23B. DATE SIGNED 4/17/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Richard L. Heppner M.D.</p>								<p>23D. ADDRESS No. Charles Gen. Hosp. No Chas. ST. Baltimore, Md.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>				<p>24B. DATE 4/24/71</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery</p>				<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 22 1971</p>				<p>25B. NAME OF REGISTRAR Robert E. Taylor, R.D.</p>				<p>25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.</p> <p>ADDRESS 1501 EAST FORT AVE.</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3941	
BIRTH NO. 71 3941		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Marhefka, Stanislaw</u>		2. DATE AND HOUR OF DEATH <u>April 12, 1971</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>House in the Pines Nursing Home</u>		A. STATE <u>Maryland</u>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>90 2525 W. Belvedere Ave.</u>		B. COUNTY <u>2401</u>	
		C. CITY OR TOWN <u>Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1411 Loydman ST.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/89</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>81</u>
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Pomiric Marhefka</u>		14. MOTHER'S MAIDEN NAME <u>UKaszik</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-3925</u>	
17. INFORMANT <u>Thelma Marhefka</u>		ADDRESS <u>1411 Loydman ST.</u>	
18. <u>4319 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Lung Abscess</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cerebral thrombosis</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 7</u> 19 <u>71</u> to <u>March 18</u> 19 <u>71</u> that (I) <u>was</u> lost saw the deceased alive on <u>March 17</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did not) view the body after death.			
23A. SIGNATURE <u>Alan B. Cohen</u>		23B. DATE SIGNED <u>4/21/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alan B. Cohen</u>		23D. ADDRESS <u>Marylander Apt.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/22/71</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	25C. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u> <u>1501 EAST FORT AVENUE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3942</u>
<p>S-124 <u>044171</u> 3942</p> <p>BIRTH NO. <u>71-07721</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Baby Boy Spiegel</u></p>		<p>2. DATE AND HOUR OF DEATH <u>3/14/71</u> <u>1600</u> P. M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Singai Hospital of Baltor, Inc.</u> <u>42</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>MD</u> COUNTY <u>Harward</u></p> <p>C. CITY OR TOWN <u>BALIT</u></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>609 WEHESKEY ST.</u></p>		
<p>5. SEX <u>M</u></p>	<p>6. RACE <u>White</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>3-14-74</u></p>	<p>9. AGE (In years last birthday) <u>12 hrs.</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		
<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		
<p>13. FATHER'S NAME <u>Louis August</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>MRS. SPIEGEL</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p>
<p>18. CAUSE OF DEATH</p>				
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Possible Congenital Heart Dis</u> 12 hr DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>II</p>				
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (1) (this hospital) attended the deceased from <u>3/14</u> 19 <u>71</u> to <u>3/14</u> 19 <u>71</u> and that (1) (we) last saw the deceased alive on <u>3/14</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <u>Victoria Schay MD</u></p>				<p>23B. DATE SIGNED <u>3/14/71</u></p>
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE <u>4-19-71</u></p>		<p>24C. NAME OF CEMETERY OR CREMATOR <u>UNIVERSITY MEDICAL SCHOOL</u></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>John E. Faber, MD.</u></p>		<p>25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u></p>

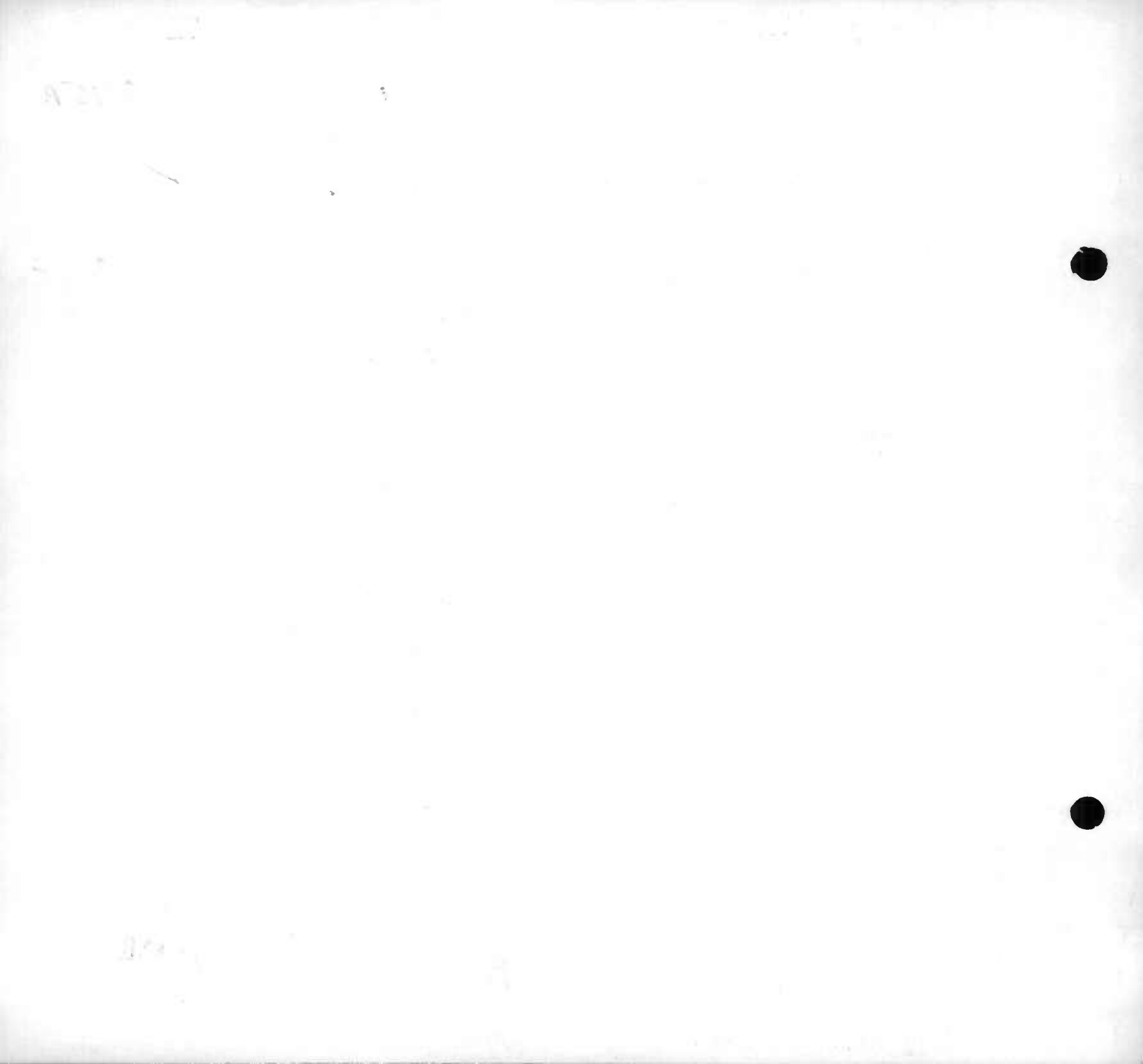
address should be Steven Forest Rd. Columbia

10/1/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

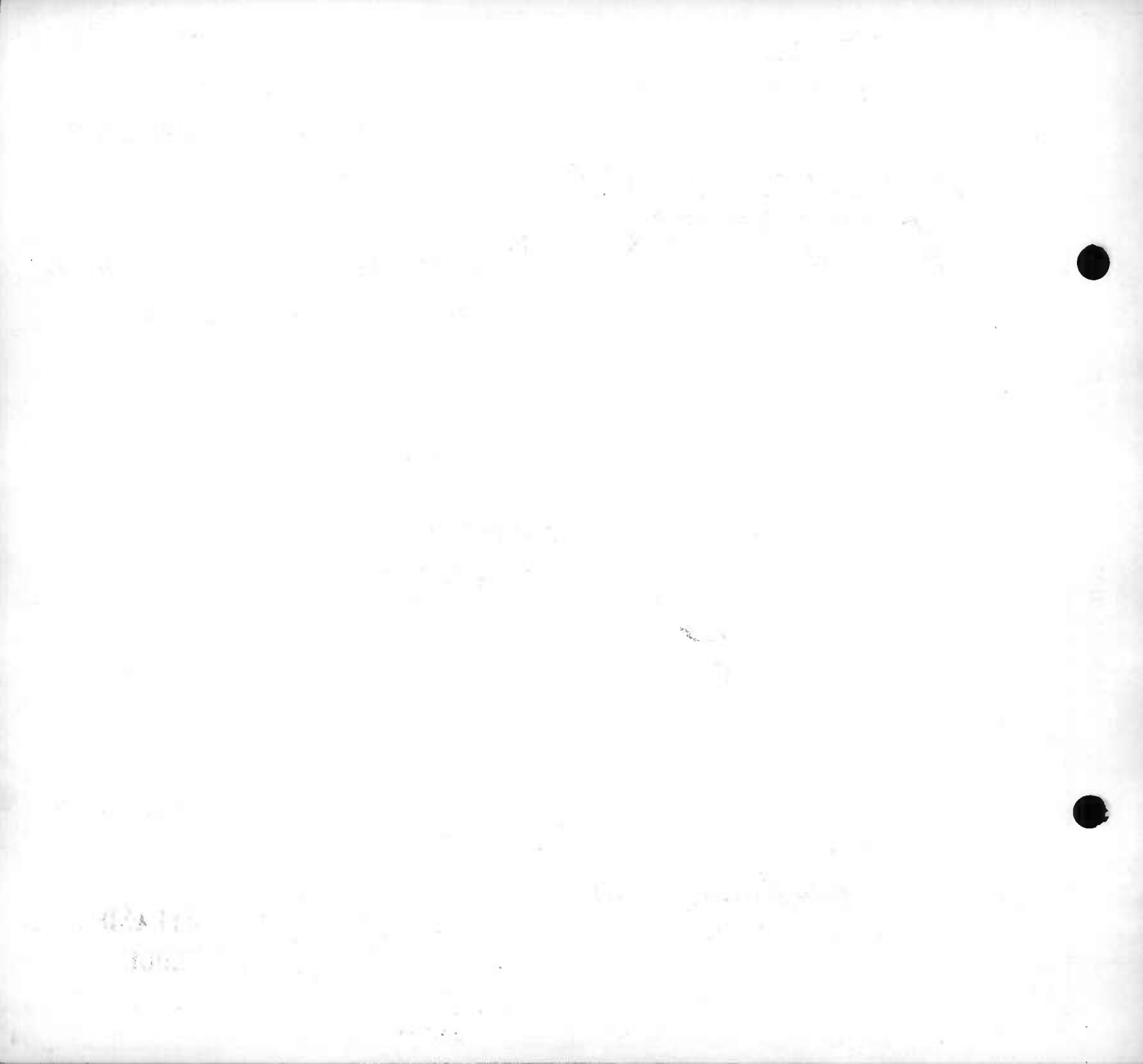
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3943	
CERTIFICATE OF DEATH					
J-212 71 3943 BIRTH NO. 71-03913		2. DATE AND HOUR OF DEATH MARCH 5, 1971 3:15 P.M.			
1. NAME OF DECEASED (Type or Print) BABY BOY JACOBS		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1101		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1101 ST PAUL ST					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3.5.71	9. AGE (In years last birthday) 3 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME LARRY JOEL JACOBS		14. MOTHER'S MAIDEN NAME LEBOFF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 759.71 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Apnea				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Since birth	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Prematurity				DUE TO, OR AS A CONSEQUENCE OF: Multiple congenital anomalies	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/5 1971 to 3/5 1971 that (I) (we) last saw the deceased alive on 3/5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Victoria Schaff</i>				23B. DATE SIGNED 3/5/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-19-71		24C. NAME OF CEMETERY OR CREMATORIUM	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BOLD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

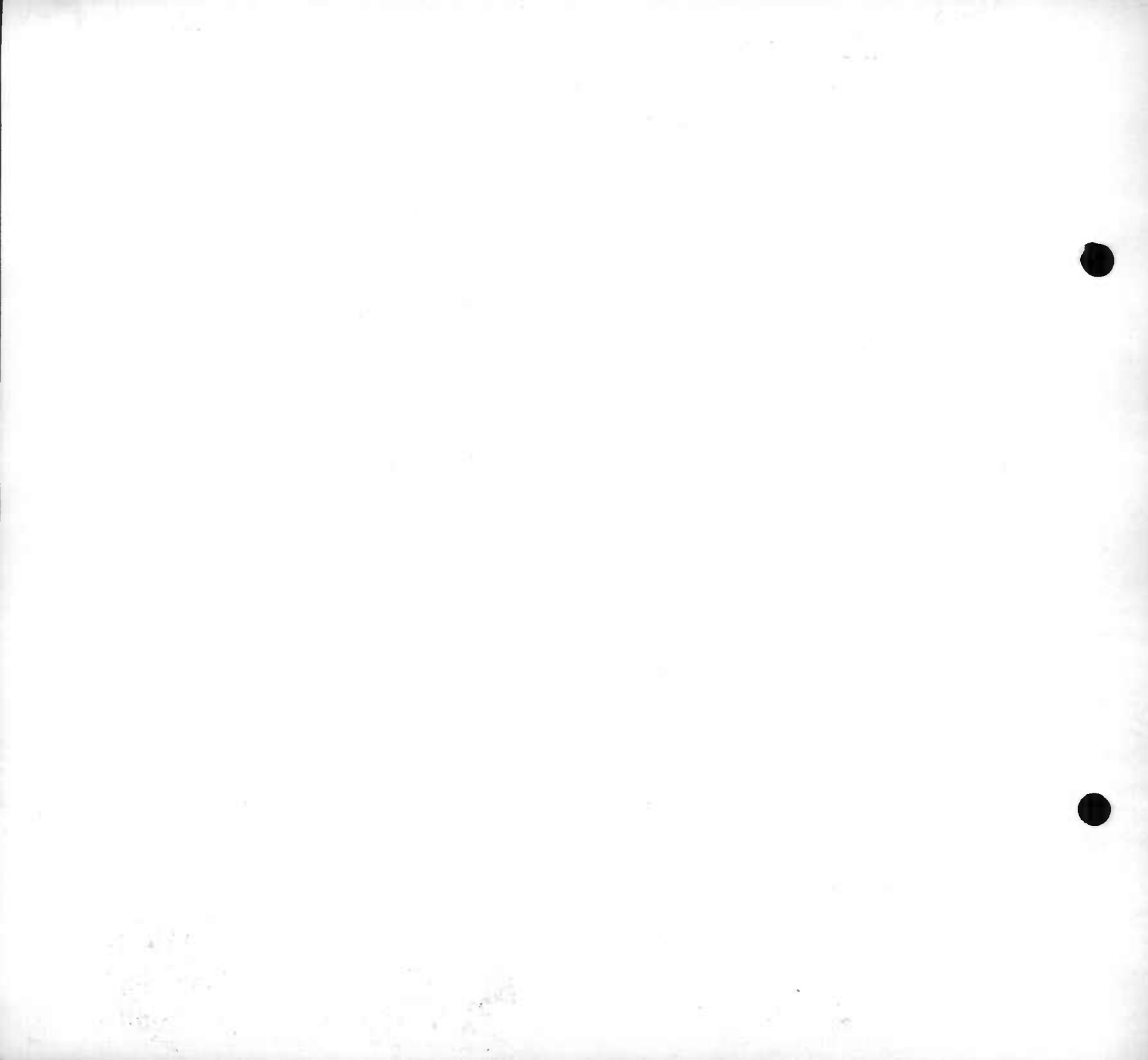
BIRTH NO. 71 3944		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3944	
1. NAME OF DECEASED (Type or Print) Baby Girl Moore		2. DATE AND HOUR OF DEATH 1/31/71 at 8:30 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE BELVEDERE AVE AT GREENSARING BALTIMORE MARYLAND		A. STATE SINAI HOSPITAL OF BALTIMORE		B. COUNTY 15/10	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3831 LIBERTY HEIGHTS AVE			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31/71 9:04 AM	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN P. MOORE			
14. MOTHER'S MAIDEN NAME MADLINE POWERS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ANOXIA DUE TO, OR AS A CONSEQUENCE OF: (B) IMMATUREITY DUE TO, OR AS A CONSEQUENCE OF: (C) PREMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9:04 AM Jan. 31 1971 to 8:30 PM Jan. 31 1971 that (I) (we) last saw the deceased alive on 8:28 PM Jan. 31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julio M Pardo		23B. DATE SIGNED 1/31/71		23C. PHYSICIAN'S NAME (Type) Julio M Pardo	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-19-71		24C. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND BALTIMORE, MARYLAND UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL HOME MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>71-0650371</u> <u>3945</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71</u> <u>3945</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
<u>BABY BOY DAVIS</u>				<u>4-14-71</u> <u>12³⁰</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSP.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Greene & Lombard</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>HOSPITAL</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2325 Calverton Heights</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-71</u>		9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY
					<u>MARYLAND</u>		<u>U.S.</u>
13. FATHER'S NAME <u>Justin Jones</u>				14. MOTHER'S MAIDEN NAME <u>Rose Davis</u>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>2325 Calverton Heights Av</u>	
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>IMMATURITY</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> <u>1971</u> to <u>4-14</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>4-14</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> MD MPH				23B. DATE SIGNED <u>4-14-71</u>		23C. PHYSICIAN'S NAME (Type) <u>F. A. AKESODE MD MPH</u>	
23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCD</u>				23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <u>4-21-71</u>		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town or county) (State)				24E. NAME OF REGISTRAR		24F. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3946	
B-300 71-03319 3946		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Boyd</i>		2. DATE AND HOUR OF DEATH <i>2-15-71 9:57 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 Sinai Hospital of Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1511</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4016 Hilton Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>Black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-71</i>	9. AGE (In years last birthday) <i>12</i>	If Under 1 Yr. Months: <i>12</i> Days: <i>45</i> If Under 24 Hrs. Hours: <i>45</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Clarence</i>			
14. MOTHER'S MAIDEN NAME <i>Phyllis</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mother</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Prematurity - 28 week gestation</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Birth weight = 960g</i> (C)			
19A. DATE OF OPERATION <i>2-14-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>2-14-71</i> to <i>2-15-71</i>, that (1) was lost saw the deceased alive on <i>2-15-71</i> and that in (my) was opinion death occurred on the date and hour and from the causes stated above. (1) was (did) did not view the body after death.					
23A. SIGNATURE <i>Louise Lisi M.D.</i>		23B. DATE SIGNED <i>2-15-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Louise Lisi M.D.</i>	
23D. ADDRESS <i>Sinai Hospital of Baltimore</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>4-19-71</i>			
24B. DATE <i>4-19-71</i>		24C. NAME OF CEMETERY or CREMATION ANATOMY BOARD OF MARYLAND			
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. APR 23 1971			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHO			

ALLEN-POHLE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3947</u>	
J-520 71 3947				BIRTH NO. <u>71-06584</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Baby Girl JONES.				4. 13. 71 1 6. 10 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
38 University of Maryland Hospital				Md. Baltimore 1501	
5. SEX 6. RACE				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
F N				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER	
8. DATE OF BIRTH 9. AGE (in years last birthday)				1621 Lorman Ct.	
4. 11. 71				10. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
Newborn				Maryland, USA U.S.A.	
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Ronald HICKS				ETTA M. JONES	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
No				Mother sl. above.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hyaline Membrane Disease					
(B) DUE TO, OR AS A CONSEQUENCE OF: Prematurity					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1 hr. since birth.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2		No		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		No		No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		No	
22. I certify that (I) (this hospital) attended the deceased from 4. 12. 1971 to 4. 13. 1971 that (I) (we) last saw the deceased alive on 4. 13. 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Elizabeth M. Ruff M.D.				4. 13. 71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Elizabeth M. Ruff M.D.				ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BGHD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
4-21-71		4-21-71		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR	
APR 23 1971		Valerie E. [Signature]		[Signature]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

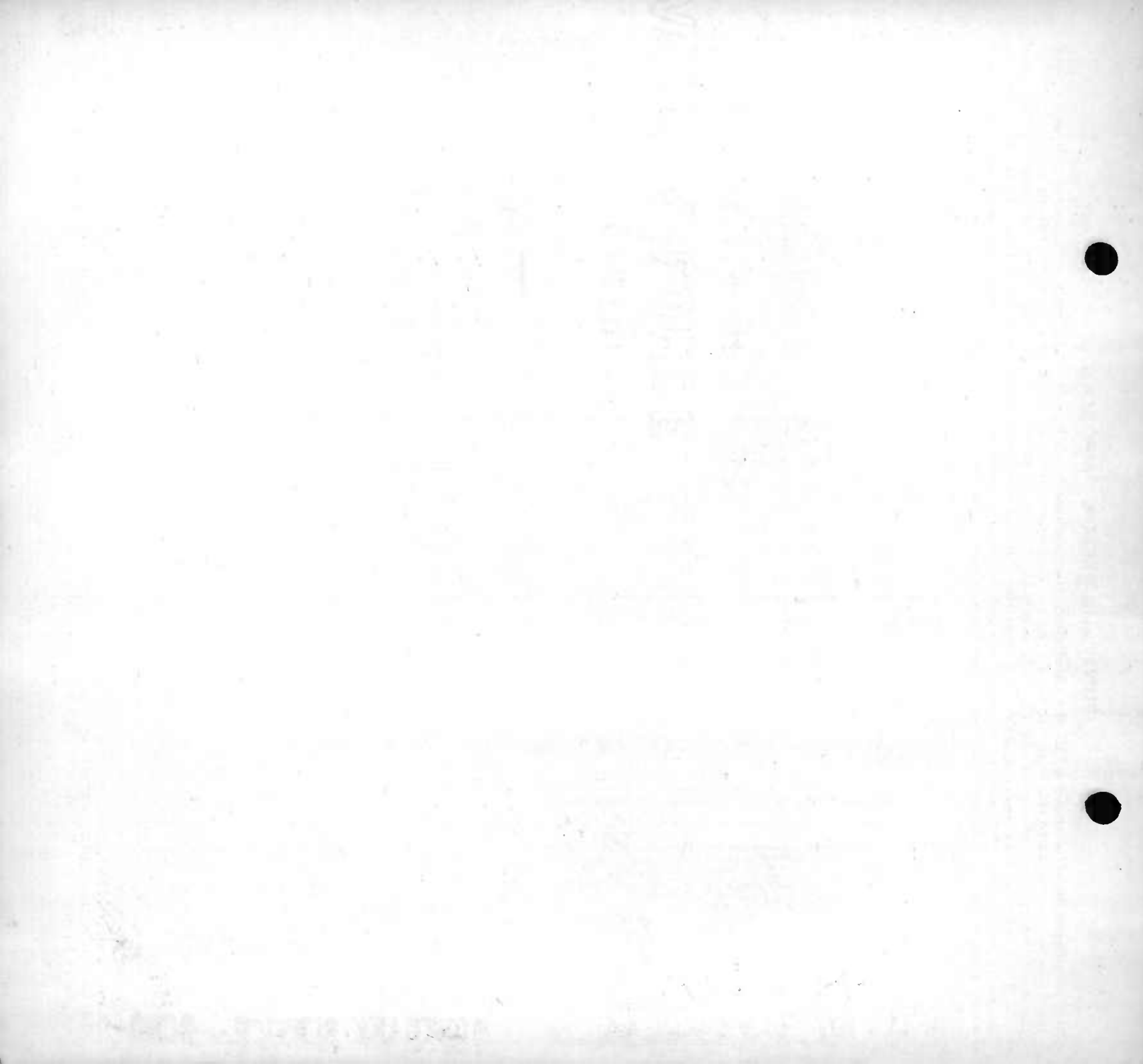
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 71 3948	
BIRTH NO. B-34671-05241		71 3948 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY GIRL BIEDLER			2. DATE AND HOUR OF DEATH 4-6-71 12:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL			A. STATE NEW BORN UNIVERSITY & MD HOSP.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 5200
			C. CITY OR TOWN BALTIMORE		
			E. STREET AND NUMBER GREENE + LOMBARD ST.		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-71	9. AGE (In years lost birthday) 8 DAYS	If Under 1 Yr. Months Days 8
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME 7		
14. MOTHER'S MAIDEN NAME MARY BIEDLER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT UNIVERSITY DR. F. A. AKESODE		
18. 776-11 CAUSE OF DEATH			ADDRESS UNIVERSITY HOSPITAL		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYALINE MEMBRANE DISEASE (B) PREMATURITY DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERBILIRUBINAEMIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 3-29 19 61 to 4-6 19 71 that (H) (we) last saw the deceased alive on 4-6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. A. AKESODE MD MPH			23B. DATE SIGNED 4-6-71		23C. PHYSICIAN'S NAME (Type) F. A. AKESODE MD MPH
24A. BURIAL CREMATION, REMOVAL (Specify) City			24B. DATE 4-21-71		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971			25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD

Rt. 1, Box 255 Davidsonville, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-525 71 3949		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3949	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LESTER BENJAMIN		2. DATE AND HOUR OF DEATH 4-16-71 5AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1601			
FULL NAME OF HOSPITAL OR INSTITUTION 1200 W. Mosher St.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balti. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1200 W. Mosher St.			
5. SEX M	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1899	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jamaica	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction? Coronary Occlusion? Hypertension HCUV (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Apr 12 1968 to Apr 9 1971 , that (I) (we) lost saw the deceased alive on Apr 9 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE George McDonald 23C. PHYSICIAN'S NAME (Type) George McDonald	
23B. DATE SIGNED 4/18/71		23D. ADDRESS See above		23E. PHYSICIAN'S NAME (Type) George McDonald	
24A. BURNAL CREMATION, REMOVAL (Specify)		24B. DATE 4-20-71		24C. NAME OF CEMETERY or BURIAL PLACE ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Reese, J. A.		25C. FUNERAL DIRECTOR'S ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BMD	



1

M-632 3950 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 3950

BIRTH NO.

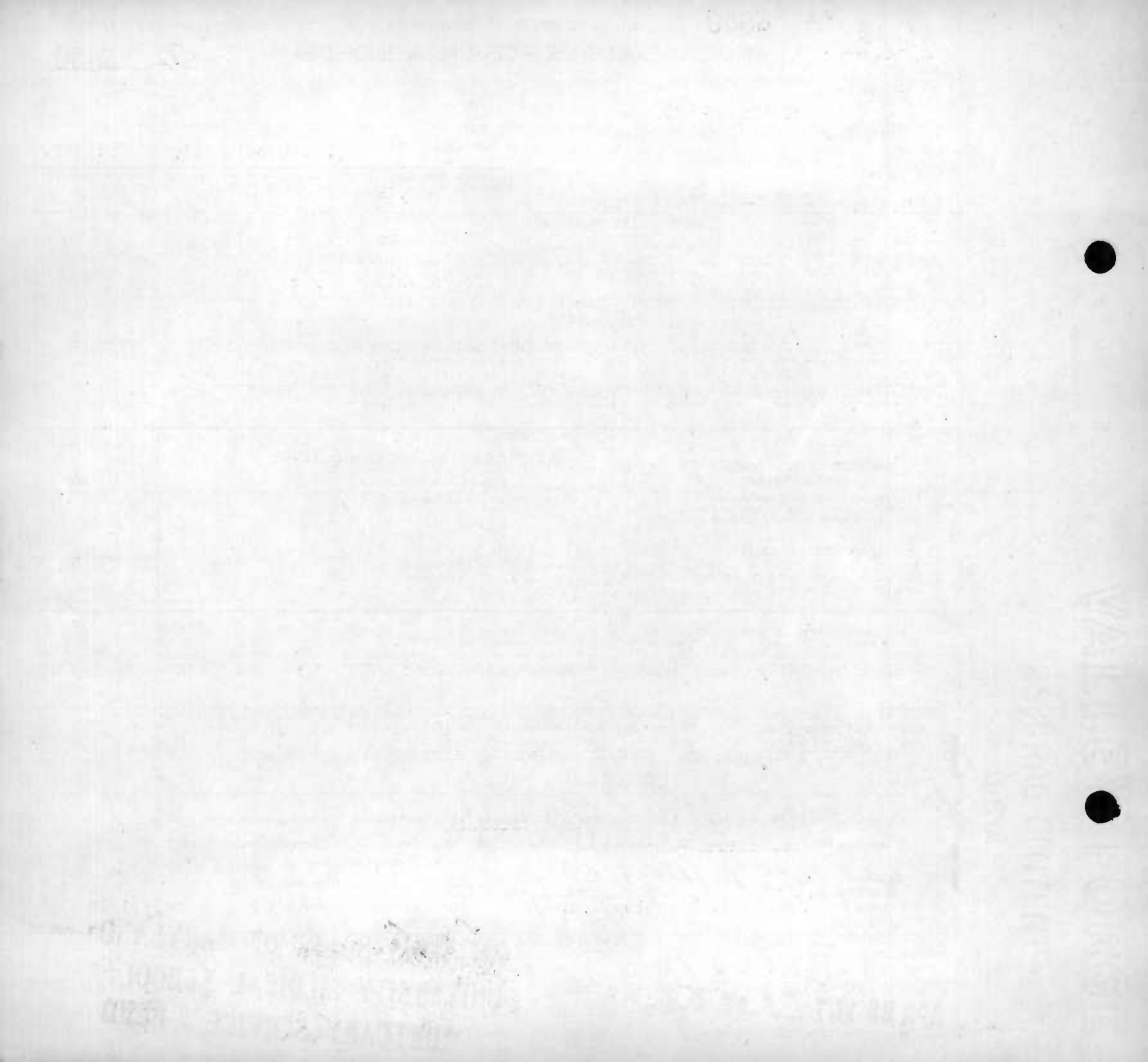
1. NAME OF DECEASED (Type or Print) WILLIE MERTZ		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) On steps of 1572 Richland Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 30, 1971 5:48 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1303	
9. DATE OF BIRTH 10. AGE (In years last birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Baltimore	
11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1552 Richland Street	
13. FATHER'S NAME		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. 571.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/31/71				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-22-71		24C. NAME OF CEMETERY or CREMATORY
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. CLINICAL DIRECTOR

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

VS 151-REV. 1/1/68



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <i>Joseph P. Laukaitis</i>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 3 27 71 7:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>00 847 Washington Blvd</i>		3. DATE PRONOUNCED DEAD 3 27 71 7:45 A.M.	
6. SEX <i>M</i>		7. RACE <i>White</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Baltimore</i>	
9. DATE OF BIRTH <i>70</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE in years (lost birthday) <i>70</i>		E. STREET AND NUMBER <i>847 Washington Blvd.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. <i>412.41</i> CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) IMMEDIATE CAUSE <i>Arteriosclerotic Cardiovascular Disease.</i> DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <i>2</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <i>Yes</i>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Werner H. Spitz</i>		DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>3.27.71</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4-22-71</i>	
24C. NAME OF CEMETERY		24D. NAME OF REGISTRAR	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 23 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SERVICE - BALD.

WILEY EARPEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3952	
<div style="display: flex; justify-content: space-between;"> M-410 71-03935 3952 </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 71-03935 1. NAME OF DECEASED (Type or Print) Baby Girl Melfa </div> <div> 2. DATE AND HOUR OF DEATH February 13, 1971 </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore Greenspring and Belvidere Baltimore, Maryland Aves </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE Sinai Hospital </div> <div style="flex: 1;"> B. COUNTY 2631 </div> </div>		
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/13/71	
13. FATHER'S NAME Chulserum		14. MOTHER'S MAIDEN NAME Constance Melfa		9. AGE (In years last birthday) <div style="display: flex;"> <div style="flex: 1;"> If Under 1 Yr. Months 10 Days 08 </div> <div style="flex: 1;"> If Under 24 Hrs. Hours 10 Min. 00 </div> </div>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<div style="display: flex;"> <div style="flex: 1;"> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 2;"> CAUSE OF DEATH (A) IMMEDIATE CAUSE Prematurity - Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="flex: 1;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
<div style="display: flex;"> <div style="flex: 1;"> 19A. DATE OF OPERATION 0 </div> <div style="flex: 1;"> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED </div> <div style="flex: 1;"> 20A. AUTOPSY? (Yes or No) </div> <div style="flex: 2;"> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> </div>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 13 19 71 to Same 19 71 that (I) (we) last saw the deceased alive on Same 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard E. Layton, M.D.				23B. DATE SIGNED February 13, 1971	
23C. PHYSICIAN'S NAME (Type) Richard E. Layton, M.D.				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-19-71		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHA	

4204 Glenarm Ave. 2/206

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

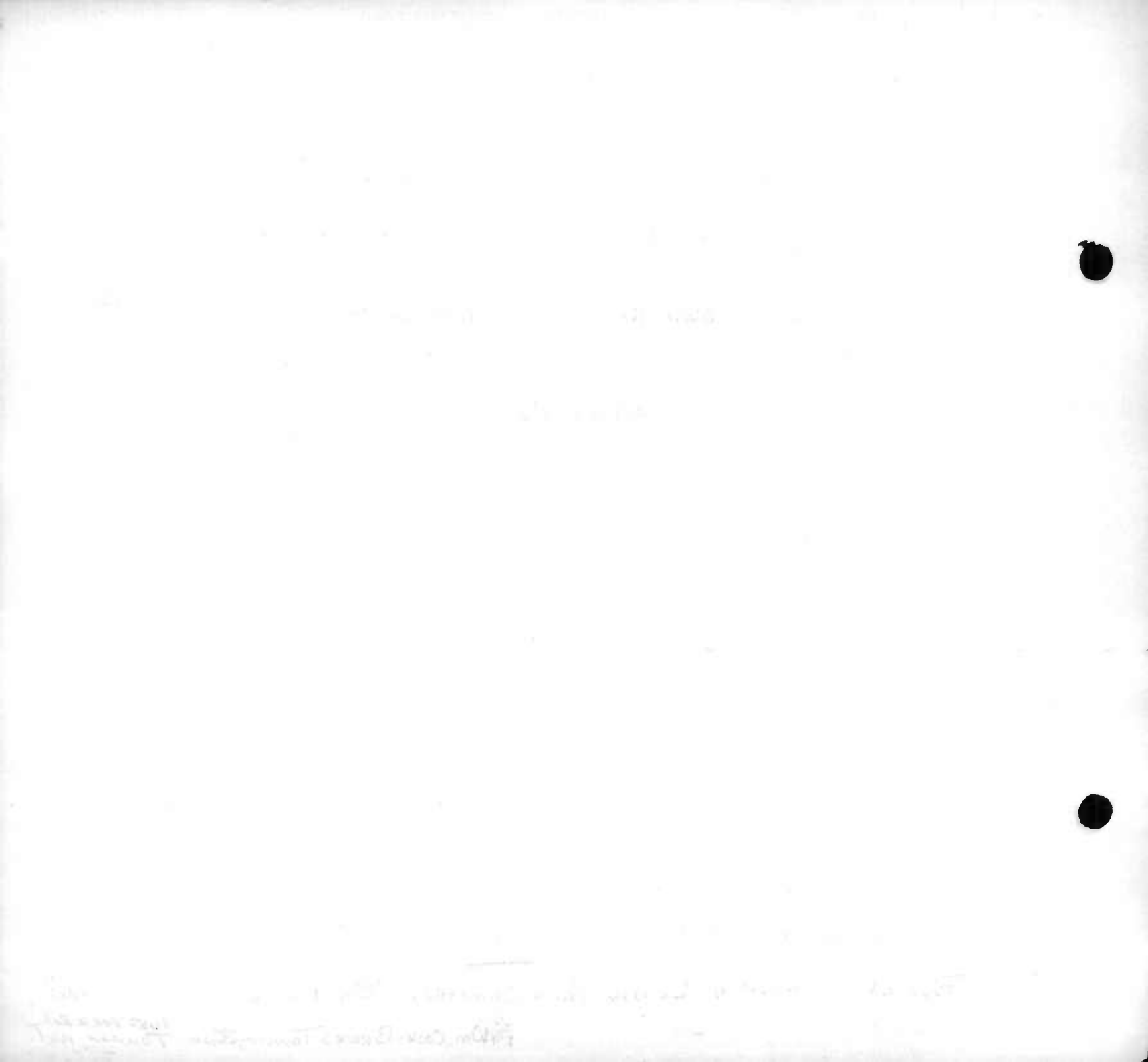
<p>W-625 71 3953</p> <p>BIRTH NO.</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>71 3953</p> <p>REG. NO.</p>	
<p>1. NAME OF DECEASED (Type or Print) WORKMAN MRS. FLORENCE P.</p>			<p>2. DATE AND HOUR OF DEATH APRIL 20, 1971 4 A M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>		
<p>FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS Hospital</p>			<p>A. STATE Maryland B. COUNTY 1903</p>		
<p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>			<p>C. CITY OR TOWN Baltimore</p>		<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>E. STREET AND NUMBER 115 S. Monroe St. 21223</p>					
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH March 26 1901</p>	<p>9. AGE (In years last birthday) 70</p>	<p>10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p>					
<p>13. FATHER'S NAME ?</p>			<p>14. MOTHER'S MAIDEN NAME ?</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 123-16-8346</p>		<p>17. INFORMANT Hospital Chart</p>	
				<p>ADDRESS</p>	
<p>18. 4/10/71 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARDIOGENIC SHOCK</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE POSTEROLATERAL MYOCARDIAL INFARCTION</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: PSEUD + ROAD + LFT CVA.</p> <p>(C)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 9-12 1971 to 4-20 1971 that (I) (we) last saw the deceased alive on 4-19 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE [Signature] MD</p>			<p>23B. DATE SIGNED 4-20-71</p>		<p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) MARCELINO F. ALBUERNE MD</p>			<p>23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 4-21-70</p>		<p>24B. DATE</p>		<p>24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL</p>	
<p>24D. LOCATION (City or County) (State) MORTUARY SERVICE - BCMD</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. APR 23 1971</p>			<p>25B. NAME OF REGISTRAR [Signature]</p>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. B-452		71 3954	
1. NAME OF DECEASED (Type or Print) Kathryn R. Billingslea		2. DATE AND HOUR OF DEATH 21 APRIL 1971 10¹⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		A. STATE Maryland B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN TOWSON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
38		E. STREET AND NUMBER 204 E. Joppa Rd.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN Home	9. AGE (In years last birthday) 88
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Zepp		14. MOTHER'S MAIDEN NAME Emma Albright	
15. Was Deceased ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-16-8515 D	17. INFORMANT The Patient
18. 4/23/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCLVD		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Old acute MI.	
(B) DUE TO, OR AS A CONSEQUENCE OF: Old acute MI.		(C) DUE TO, OR AS A CONSEQUENCE OF: Old acute MI.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Probable Gall Bladder Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 4/21/71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiac pacing	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 18 Apr 71 to 21 Apr 71 and that (I) (we) last saw the deceased alive on 21 Apr 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Philip A. Mackowick		23B. DATE SIGNED 4/21/71	
23C. PHYSICIAN'S NAME (Type) PHILIP A. MACKOWICK		23D. ADDRESS UNIV. OF Md. Hosp. Balto., Md.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-24-71	24C. NAME OF CEMETERY OR CREMATOR Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR John E. Kelly, Jr.	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc.		25D. ADDRESS 1050 York Rd. Towson, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3955	
BIRTH NO. H-621		71 3955		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Rabbi HERMAN HERZBERG			2. DATE AND HOUR OF DEATH 3:10 AM 4/22/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2740 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6210 Wallis Ave		
5. SEX MALE 6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 14 1894 9. AGE (In years last birthday) 77 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RABBI			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Abraham Herzberg		
14. MOTHER'S MAIDEN NAME Fish, Breindel			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Irving Herzberg ADDRESS 7004 Baxford Rd.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Hours </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE CARDIOGENIC Shock DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION. </div> <div style="width: 35%;"> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: </div> </div>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				X REG. NO. 71 3956	
BIRTH NO. P-160		1. NAME OF DECEASED (Type or Print) Bernard H. Pifer BERNARD H. PIFER		2. DATE AND HOUR OF DEATH 4/20/71 11:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. GEN. HOSP. Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3819 Annadale Rd Md 21222		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/02		9. AGE (in years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. MAN		10B. KIND OF BUSINESS OR INDUSTRY North Point Drive-in		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Daniel Pifer		
14. MOTHER'S MAIDEN NAME Pearl ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-01-3191			17. INFORMANT ADDRESS Wife: EULA PIFER (same)		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ventricular fibrillation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myocardial infarction					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia - R. lung - Hypoxia					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypoxia		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Md. General Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Md. General Hospital			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/19 19 71 to 4/20 19 71 that (I) (we) last saw the deceased alive on 4/20 19 71 and that in (my) (our) opinion death occurred on the date 4/20 19 71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. N. Mavridis					
23B. DATE SIGNED 4/20/71					
23C. PHYSICIAN'S NAME (Type) A. N. MAVRIDIS					
23D. ADDRESS Md. General Hospital, Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.	

Box 212
92

10/15/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-410 71 3957		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3957	
1. NAME OF DECEASED (Type or Print) Eleanor M. Gilboy		2. DATE AND HOUR OF DEATH 4/20/71 4:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3604 Xxxxxxxx. 4502 Carlyn Rd Perry Hall			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/85	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Gilboy		14. MOTHER'S MAIDEN NAME Elizabeth Murray	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-22-5232		17. INFORMANT John Kastendike-4502 Carlyn Rd Perry Hall Hospital Records Maryland	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days Years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-12 19 71 to 4-20 19 71 that (I) (we) last saw the deceased alive on 4-20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benedict A. Termini		23B. DATE SIGNED 4/21/71		23C. PHYSICIAN'S NAME (Type) BENEDICT A. TERMINI	
23D. ADDRESS MERCY HOSPITAL, BALTIMORE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4-23-1971		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Armacost Funeral Chapel-4600 Liberty Hts	

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

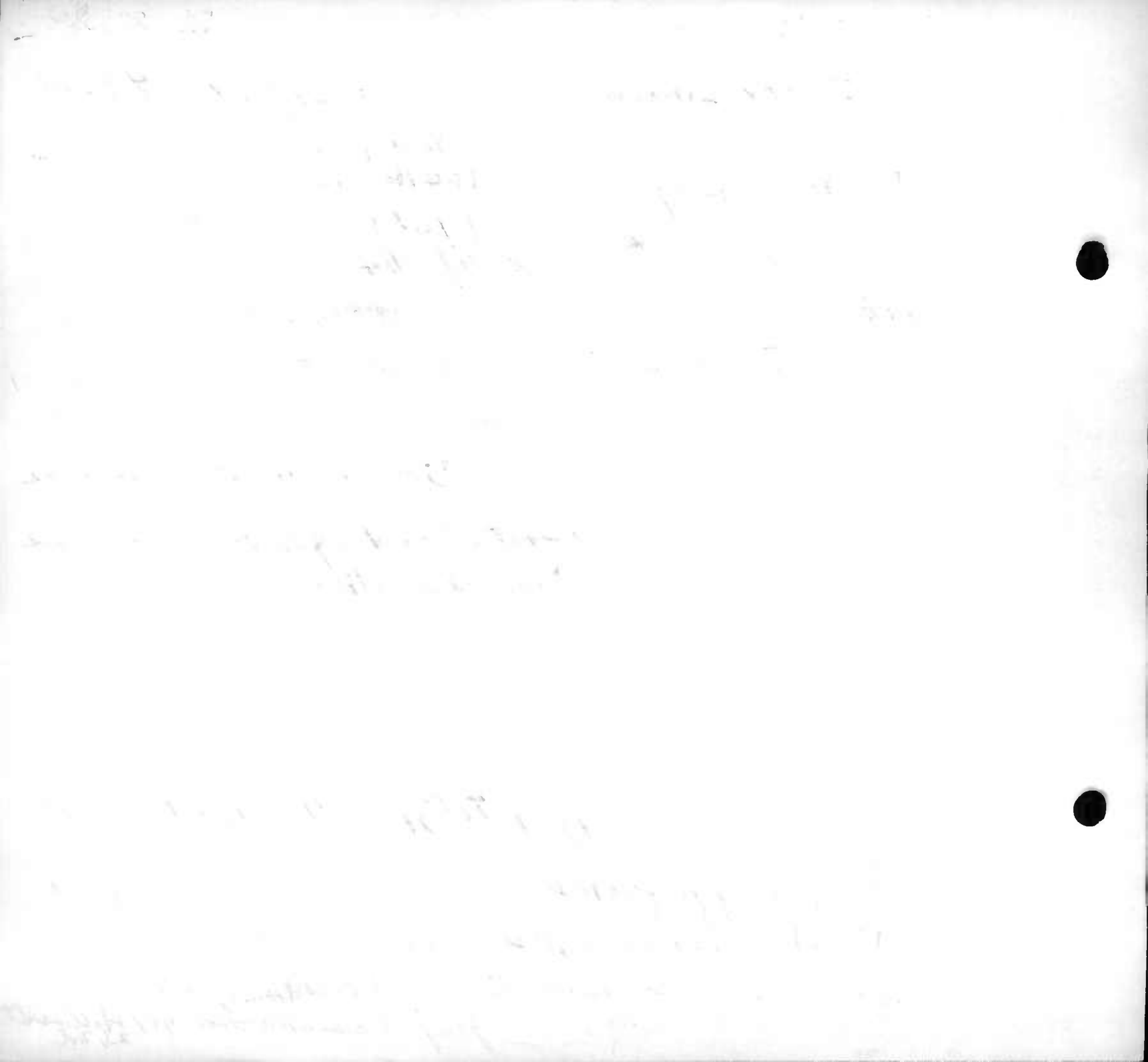
130

131

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO.	
L-535 71 3958										71 3958	
BIRTH NO.										W.	
1. NAME OF DECEASED (Type or Print) <u>Joseph Lindamood</u>					2. DATE AND HOUR OF DEATH <u>4/21/71</u> <u>4 PM</u> M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION <u>380 of Md. Hosp</u>					A. STATE <u>Md</u> B. COUNTY <u>BALTO</u>						
					C. CITY OR TOWN <u>1803</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
E. STREET AND NUMBER <u>1411 Hollins St</u>					F. STREET AND NUMBER <u>21223</u>						
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/14</u>	9. AGE (In years last birthday) <u>56</u>	10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William Franklin Lindamood</u>					14. MOTHER'S MAIDEN NAME <u>Bertie Jordan</u>						
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>-</u>						
17. INFORMANT <u>Luther Lindamood</u>					ADDRESS <u>21061 Glenview Dr. 234 Poplar Hne.</u>						
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE <u>Cirrosis, Ascites</u> <u>2 weeks</u>											
(B) <u>Hepato Renal Syndrome</u> <u>2 weeks</u>											
(C) <u>Chronic Alcoholism</u>											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> 19 <u>71</u> to <u>4/21</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Joseph Sappington MD</u>								23B. DATE SIGNED <u>4/21/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Joseph Sappington MD</u>								23D. ADDRESS <u>U. of Md. Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/24/71</u>			24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>			24D. LOCATION (City, town, or county) <u>Glenview, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>			25C. FUNERAL DIRECTOR <u>John J. Sappington Inc.</u>			ADDRESS <u>907 Hollins St 23, Md.</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Fred W. Kastel

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

2631

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

27 April 1910

10. AGE (In years
lost birthday)

60

11. Under 1 Yr. 12 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4438 Forest View Ave.

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ferdinand Kastel

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tool Maker

14B. KIND OF BUSINESS OR INDUSTRY

Bendix

15. MOTHER'S MAIDEN NAME

Marie Hecca

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (if yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

211-03-17168

18. INFORMANT

Rose M. Kastel 4438 Forest View Ave. Balto.

ADDRESS

21206

E98010

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Barbiturate poisoning
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4438 Forest View Ave.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 4 18 71 ? m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

ingested overdose of barbiturates

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type) Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

4/20/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-22-71

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Parkville

Balto.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 23 1971

25B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Lassahn Funeral Home 7401 Belair Rd. 21236

ACADEMIC GROUP

11/11/11

CERTIFICATE OF DEATH

REG. NO.

71 3960

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MURRAY, DOUGLAS DUNDAS

2. DATE AND HOUR OF DEATH

APRIL 19, 1971

3:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229

A. STATE

B. COUNTY

MARYLAND BALTIMORE

21229

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

4617 BRAIRCLIFT ROAD

2834

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

05/17/09

9. AGE (in years
lost birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY

PRINTING

11. BIRTHPLACE (State or foreign country)

CONNECTICUT

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES MURRAY

14. MOTHER'S MAIDEN NAME

LUCINDA (DUNDAS)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW 2

16. SOCIAL
SECURITY NO.

137-07-8742

17. INFORMANT

BALTO MD 21229

ADDRESS

ST AGNES' RECORDS CATON & WILKENS AVES

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

X 1 WK

X 1 WK

X 1 WK

X 1 WK

X 1 WK

X 1 WK

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

4/9/1971

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 5 19 71 to APRIL 19 19 71
that (I) (we) lost saw the deceased alive on APRIL 19 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.

23A. SIGNATURE

S. MALAISRIE, M.D.

DEGREE

Attending ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/15/71

23C. PHYSICIAN'S
NAME (Type)

S. MALAISRIE, M.D.

DEGREE

23D. ADDRESS

ST AGNES' RECORDS

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 23 1971

25B. NAME OF REGISTRAR

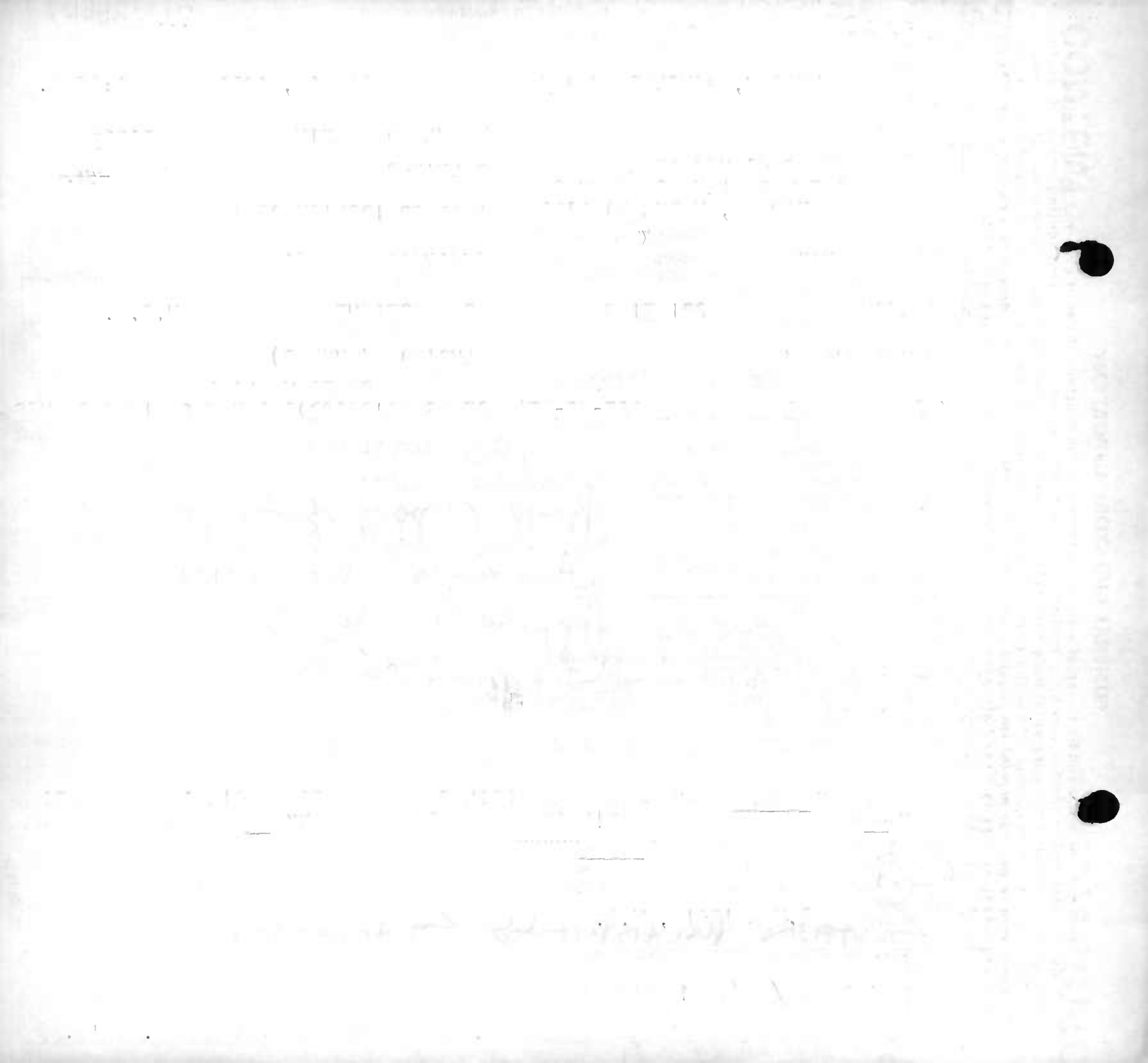
25C. FUNERAL DIRECTOR

ADDRESS

G. Truman Schwab 5151 Balto. Nat'l Pike

FUNERAL DIRECTOR: IMPORTANT

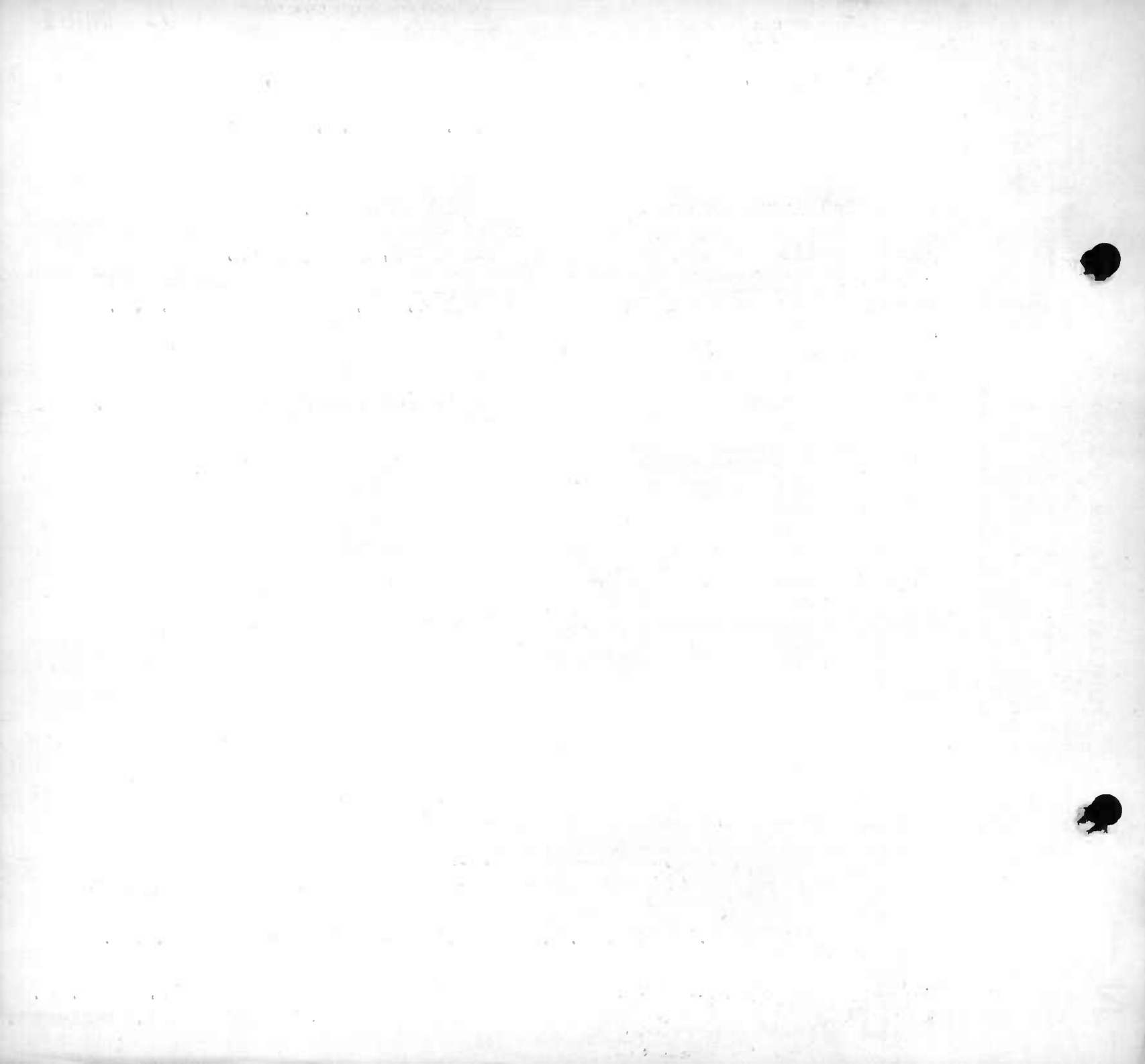
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
71 3961		71 3961		71 3961	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 1-525</p> <p>1. NAME OF DECEASED (Type or Print) Michael B. Jenkins</p> </div> <div> <p>2. DATE AND HOUR OF DEATH April 19, 1971 3 P. M.</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4-3 South Baltimore General</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY A.A. County 5200</p> <p>C. CITY OR TOWN Brooklyn D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 308 14th Ave.</p>		
<p>5. SEX male</p>	<p>6. RACE white</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH March 27, 1908 65 yrs.</p>	<p>9. AGE (In years last birthday) 65 yrs.</p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Four Roses</p>		<p>11. BIRTHPLACE (State or foreign country) Balto. Md.</p>	
<p>13. FATHER'S NAME William Jenkins</p>			<p>14. MOTHER'S MAIDEN NAME Mary Ann</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none</p>		<p>16. SOCIAL SECURITY NO. 215 010198</p>		<p>17. INFORMANT Katherine Jenkins ADDRESS 308 14th Ave.</p>	
<p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF: Hypothyroidism</p> </div> </div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>MEDICAL CERTIFICATION</p> <p>19A. DATE OF OPERATION 6 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II</p> <p>19C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 2-23-1971 to 4-19-1971, that (I) (we) lost saw the deceased alive on 4-7-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE </p>				<p>23B. DATE SIGNED 4-20-71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Ewald H. Weiss, M.D.</p>		<p>23D. ADDRESS 615 Hammonds Lane Balto. Md.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 4/22/71</p>		<p>24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery</p>	
<p>24D. LOCATION (City, town, or county) (State) Old Frederick Rd. Balto. Md.</p>		<p>25A. DATE REC'D BY HEALTH DEPT. APR 23 1971 25B. NAME OF REGISTRAR Robert E. Kelly, M.D.</p>			
<p>25C. FUNERAL DIRECTOR KRAUSE Funeral Home 1216 S. Charles St.</p>				<p>ADDRESS</p>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 3962

BIRTH NO.

70-18435

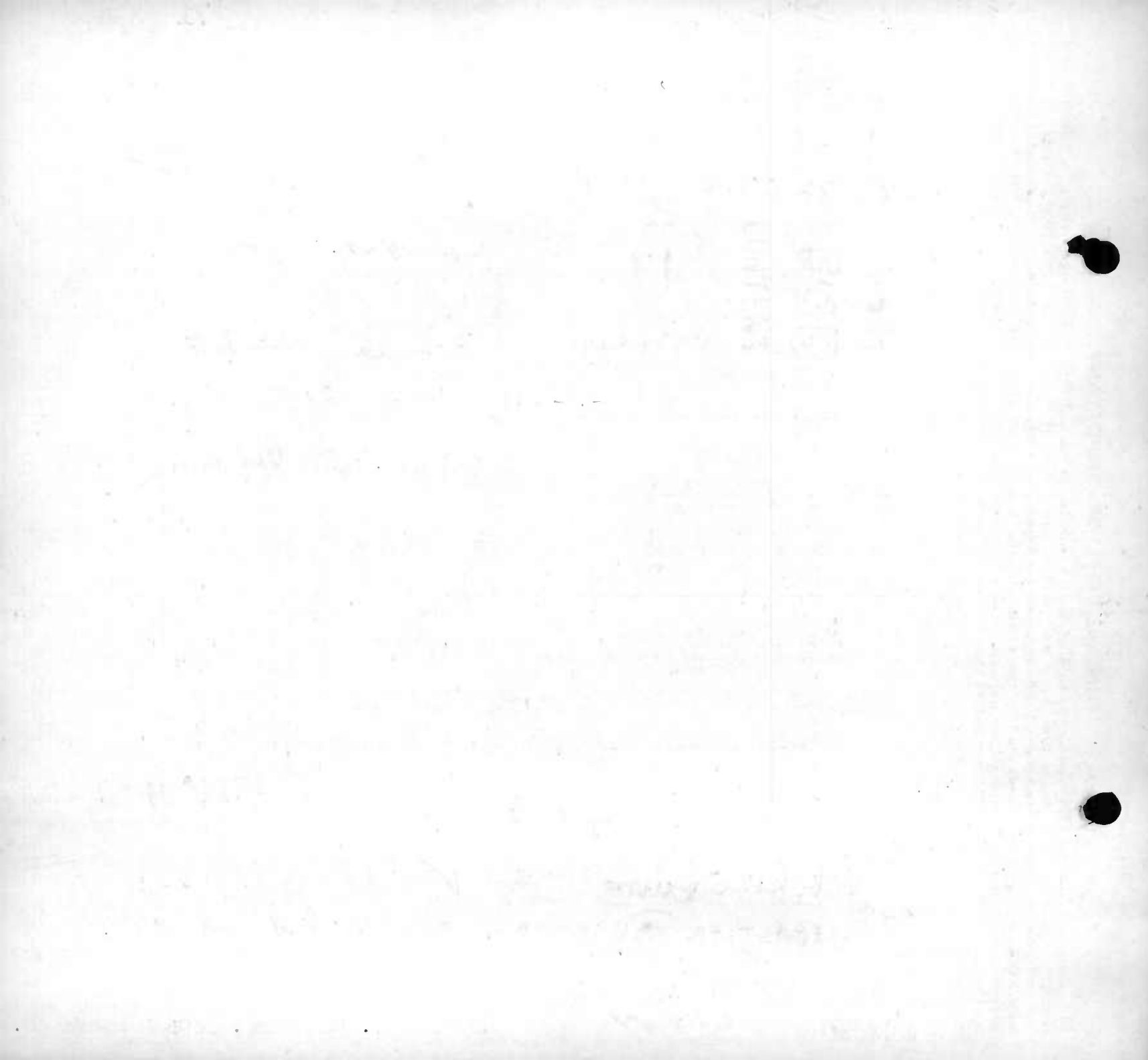
1. NAME OF DECEASED (Type or Print) JAMES LANCASTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1971 4:55 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Columbia	
9. DATE OF BIRTH Oct. 8, 1970		10. AGE (In years last birthday) 6	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT James B. Lancaster		ADDRESS 5135 Ellicott Oak Road, Columbia, Md.	
19. E 8/12, 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Multiple Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 4-15-71 2:30 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rt. 1.8 and Rt. 29		22F. HOW DID INJURY OCCUR? Passenger in auto-auto collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/71	
24C. NAME OF CEMETERY or CREMATORY Lincoln Memorial Cem.		24D. LOCATION (City, town, or county) (State) Suitland, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR John T. Rhines	
25C. FUNERAL DIRECTOR JOHN T. RHINES CO.		ADDRESS 3015 12th St., N.E.-D.C.	

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3963	
<div style="display: flex; justify-content: space-between;"> S-600 71 3963 71 3963 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) SERVO, Rose			2. DATE AND HOUR OF DEATH April 21, 1971 12:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2741		
FULL NAME OF HOSPITAL OR INSTITUTION 5222 Biddison Lane			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5222 Biddison Lane		
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25 1875	9. AGE (In years last birthday) 95	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Widow.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cefalu - Italy	
12. CITIZEN OF WHAT COUNTRY? Italian		13. FATHER'S NAME Francesco Carnaggio		14. MOTHER'S MAIDEN NAME Rosalia Feritta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-50-3211		17. INFORMANT ADDRESS Son 2733 Wegworth Lane	
18. 412.31 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 3 1960 to April 19 1971, that (I) (we) last saw the deceased alive on April 19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo				23B. DATE SIGNED 4-21-71	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO				23D. ADDRESS 5017 Harford Rd Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3964</u>	
BIRTH NO. <u>T-624</u> <u>71 3964</u>					
1. NAME OF DECEASED (Type or Print) <u>Maria Kristina Thorssell</u>		2. DATE AND HOUR OF DEATH <u>April 20, 1971</u> <u>6^{PM}</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>329 East 29th St</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>329 East 29th St</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899</u> <u>3/3/1899</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Nilsson</u>			
14. MOTHER'S MAIDEN NAME <u>-</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>no</u>			
16. SOCIAL SECURITY NO. <u>217-20-8736</u>		17. INFORMANT ADDRESS <u>Karl E. Thorssell 1600 Wadsworth Way</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma primary urinary bladder & prostate</u> <u>Bladder & prostate</u> <u>metastases to glands & liver</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6-9 months</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>-</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1971</u> to <u>April 20th 1971</u> that (I) (we) last saw the deceased alive on <u>April 20 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W.H. Woody M.D.</u>		23B. DATE SIGNED <u>4-22-71</u>		23C. PHYSICIAN'S NAME (Type) <u>W.H. Woody M.D.</u>	
23D. ADDRESS <u>1403 Park Ave Baltimore, Maryland</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4/23/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Pk</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J Ruck Inc. Baltimore, Md</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3965</u>	
K-215 71 3965		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) PAULINE KOCOVINOS		2. DATE AND HOUR OF DEATH APRIL 20, 1971 16 05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1202 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3233 ST. PAUL STREET			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/1902	9. AGE (in years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Smirna, Turkey	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Moslo			
14. MOTHER'S MAIDEN NAME -		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Alex Korvin same ADDRESS same			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. coronary heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: coronary heart disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 7 + yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Prior Myocardial infarction					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/11/63 19 to 4/20/71 19 that (I) (we) last saw the deceased alive on 4/20/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William F. Renner				23B. DATE SIGNED APRIL 21, 1971	
23C. PHYSICIAN'S NAME (Type) WILLIAM F. RENNER M.D.				23D. ADDRESS 3222 ST. PAUL STREET BALTIMORE MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/23/71		24C. NAME OF CEMETERY OR CREMATORY GREEK ORTHODOX CEMETERY	
24D. LOCATION (City, town, or county) BALTIMORE MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 23 1971			
25B. NAME OF FUNERAL DIRECTOR LEONARD J. RUCK INC.		25C. FUNERAL DIRECTOR ADDRESS 5305 HSRFORD RD. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

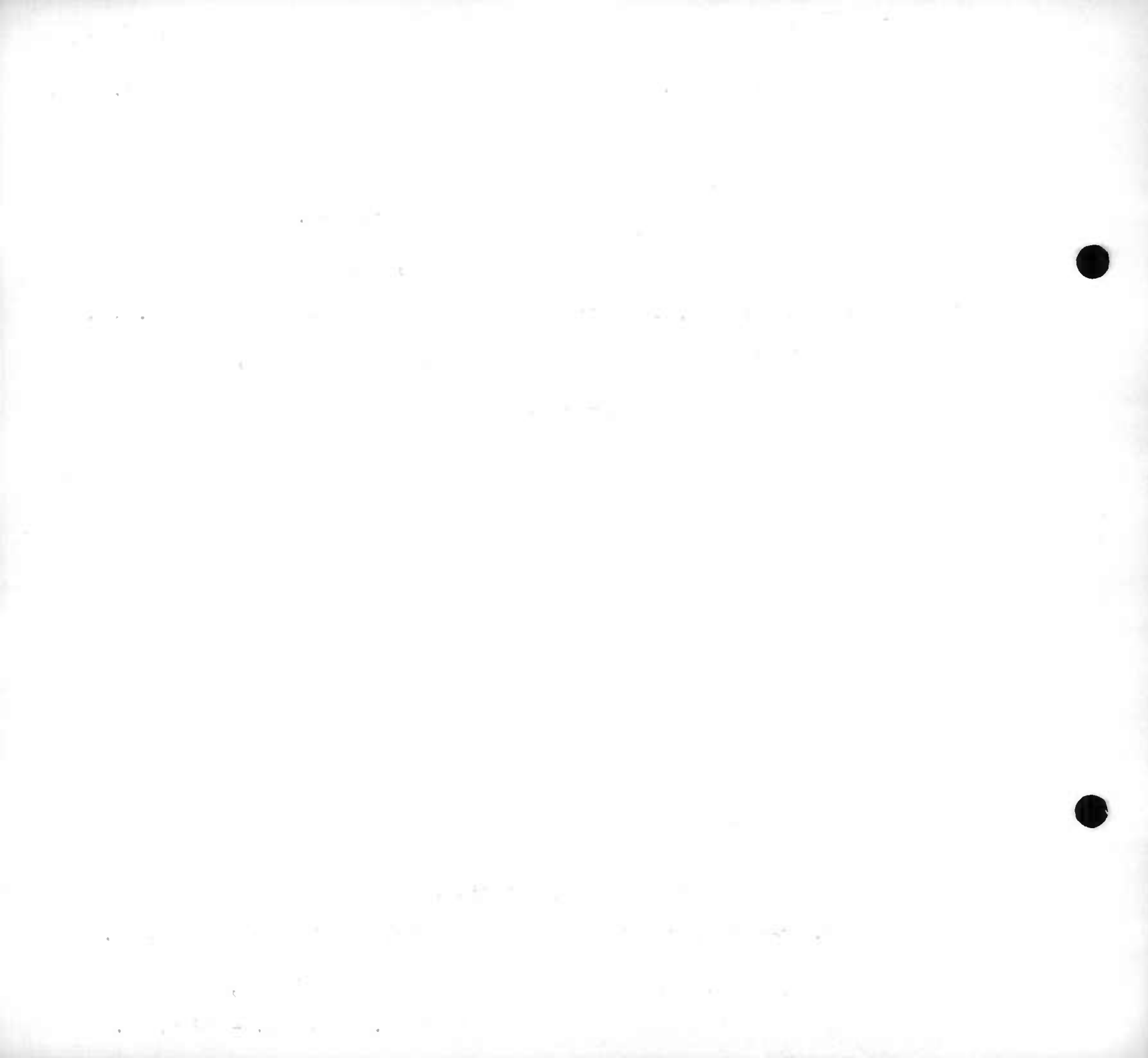
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3966	
BIRTH NO. N-200 71 3966		1. NAME OF DECEASED (Type or Print) Casimer J. Niec			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4106 Doris Ave. Baltimore Md.		2. DATE AND HOUR OF DEATH 4/20/71 M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2544 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4106 Doris Ave			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-20	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10B. KIND OF BUSINESS OR INDUSTRY C&P Telephone Company		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Roman Niec			14. MOTHER'S MAIDEN NAME Ida Pele		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 219-01-4922		17. INFORMANT Mary Jo	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1953 19 to 3/15/71 19 that (I) (we) last saw the deceased alive on 3/15/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4/21/71	
23C. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski				23D. ADDRESS 4016 Ritchie Hwy Balto 25, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71		24C. NAME of CEMETERY or CREMATORY Glen Haven	
24D. LOCATION (City, town, or county) (State) Glen Burnie Md.		25A. DATE REC'D BY HEALTH DEPT. APR 23 1971 25B. NAME OF REGISTRAR R. E. Fisher, Md.			
25C. FUNERAL DIRECTOR John H. Hahn Funeral Home				ADDRESS 4000 Pennington Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 3967</u>
BIRTH NO. <u>B-53571 3967</u>				
1. NAME OF DECEASED (Type or Print) <u>CESARIO B. BONTROYAN</u>		2. DATE AND HOUR OF DEATH <u>April 20, 1971 12.05 a. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4114 Montana Avenue</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2734</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4114 Montana Ave.</u>		
5. SEX <u>male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1903</u>	9. AGE (in years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Philippine Islands</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Eleuterio Bontoyan</u>		
14. MOTHER'S MAIDEN NAME <u>Genoveva Barron, Genoveva</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		
16. SOCIAL SECURITY NO. <u>215-01-6589</u>		17. INFORMANT <u>Mrs Dorothy Bontoyan</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>WIDESPREAD CARCINOMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CA of PANCREAS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Gracito V. Patricio</u> DEGREE				23B. DATE SIGNED <u>4/20/71</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. Gracito V. Patricio</u> DEGREE				23D. ADDRESS <u>4413 Moravia Road, Balto, Md.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/24/71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. - Balto, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

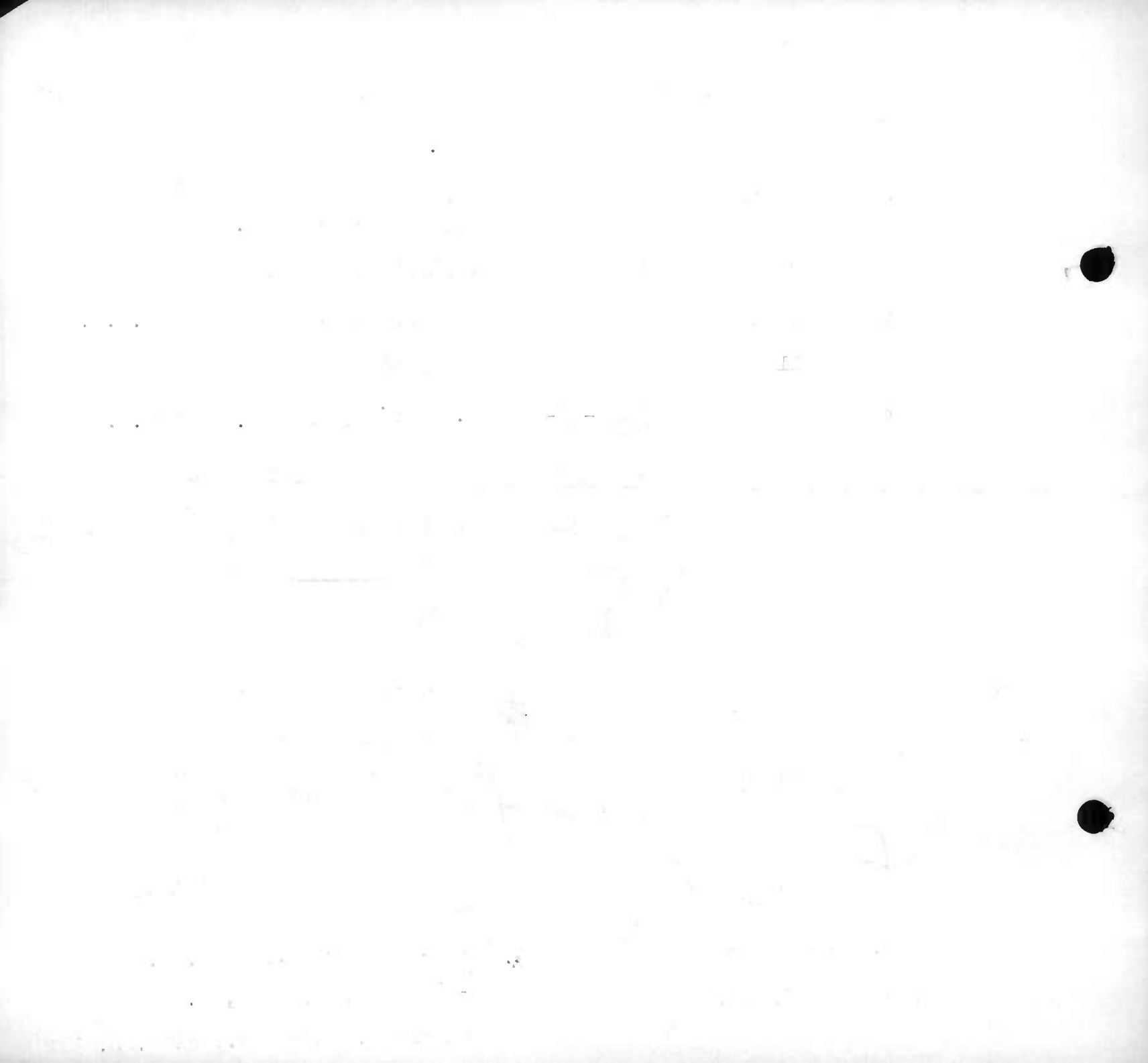
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3968	
G-355 71 3968				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM GOODMAN		2. DATE AND HOUR OF DEATH 4-20-1971 - 10:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 831		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-12-98		9. AGE (In years last birthday) 72		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Guard		11. BIRTHPLACE (State or foreign country) SICILY- ITALY	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME LUCIAN GOODMAN		14. MOTHER'S MAIDEN NAME GIACOMINA Giacomina Palermo	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 212-03-0258		17. INFORMANT U.M.H. HISTORY ADMISSION SHEET	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last)		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-30-71 to 4-20-71 that (I) (we) last saw the deceased alive on 4-20-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Juan M. Calderon		23B. DATE SIGNED 4-20-71		23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON V.	
23D. ADDRESS U.M.H.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/71	
24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) Baltimore Maryland		(State)	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-463 71 3969		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 3969	
1. NAME OF DECEASED (Type or Print) Winfield D. Ballard		2. DATE AND HOUR OF DEATH April 19, 1971 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 90 Mt. Sinai Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2743		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Mt. Sinai Nursing Home		E. STREET AND NUMBER 3502 Rueckert Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1885	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Ballard		14. MOTHER'S MAIDEN NAME Ruth ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 26-03-3274		17. INFORMANT Mrs. Dorothy Shirey A. 3201 Ailsa Ave. Balto. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCUO		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF: Recent pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3502 Rueckert Ave, Balto 2743	
21D. TIME OF INJURY (Approx.) 3 23 71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell in room next to bed	
22. I certify that (I) (this hospital) attended the deceased from 4/15 to 4/18 19 71 and that (I) (we) last saw the deceased alive on 4/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. George Vash		23B. DATE SIGNED 4/18/71		23C. PHYSICIAN'S NAME (Type) Dr. George Vash	
23D. ADDRESS 206 S. Gilmore St., Balto Md.		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/71		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Md.		24E. STATE			
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Leonard J. Ruck Inc., Balto. Md. 21214		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 3970

BIRTH NO. 71 3970		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) Emily K. Cooper		2. DATE AND HOUR OF DEATH 4/22/1971 7.45AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE GOOD SAMARITAN HOSPITAL 5601 Loch Raven Boulevard Baltimore, Maryland, 21239		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4831 Gilray Drive, 21214	
5. SEX F	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/16/28
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years last birthday) 43 If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hall		14. MOTHER'S MAIDEN NAME Margaret Squirel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/O		16. SOCIAL SECURITY NO. 218-306747	
17. INFORMANT Husband and Hospital records		ADDRESS	
18. 183.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF OVARY WITH EXTENSIVE METASTASIS, INCLUCING CEREBRAL		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1st 1971 to April 22nd 1971 , that (I) (we) last saw the deceased alive on April 22nd 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Caridad E. Gonzalez, M.D.		23B. DATE SIGNED 4/22/71	
23C. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		23D. ADDRESS THE GOOD SAMARITAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/26/71	24C. NAME OF CEMETERY or CREMATORY Pleasant Rest	24D. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR Wm. L. Chittman		ADDRESS 1701 N. Charles St. Baltimore, Md.	

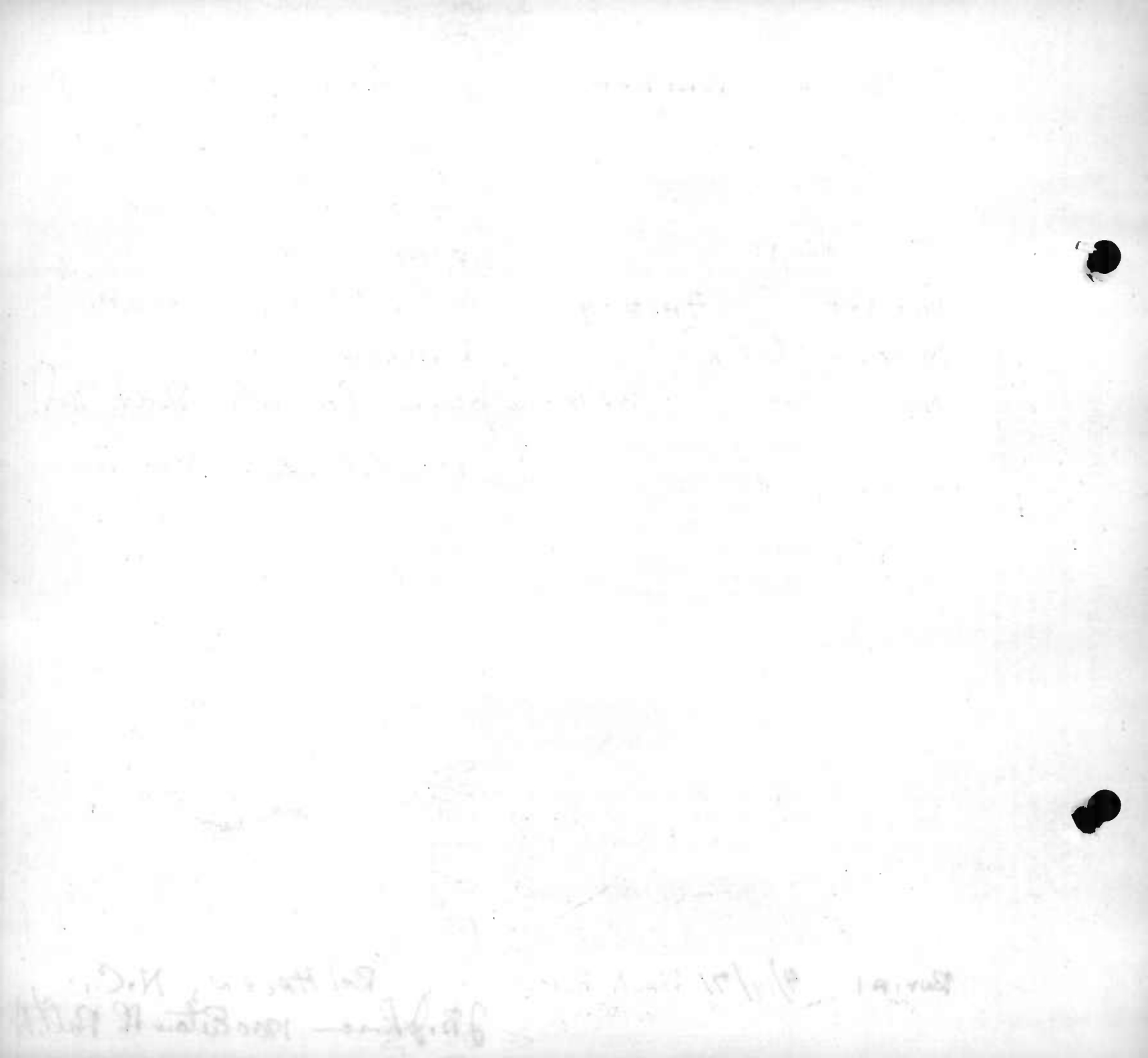
425

Received 7/20/11

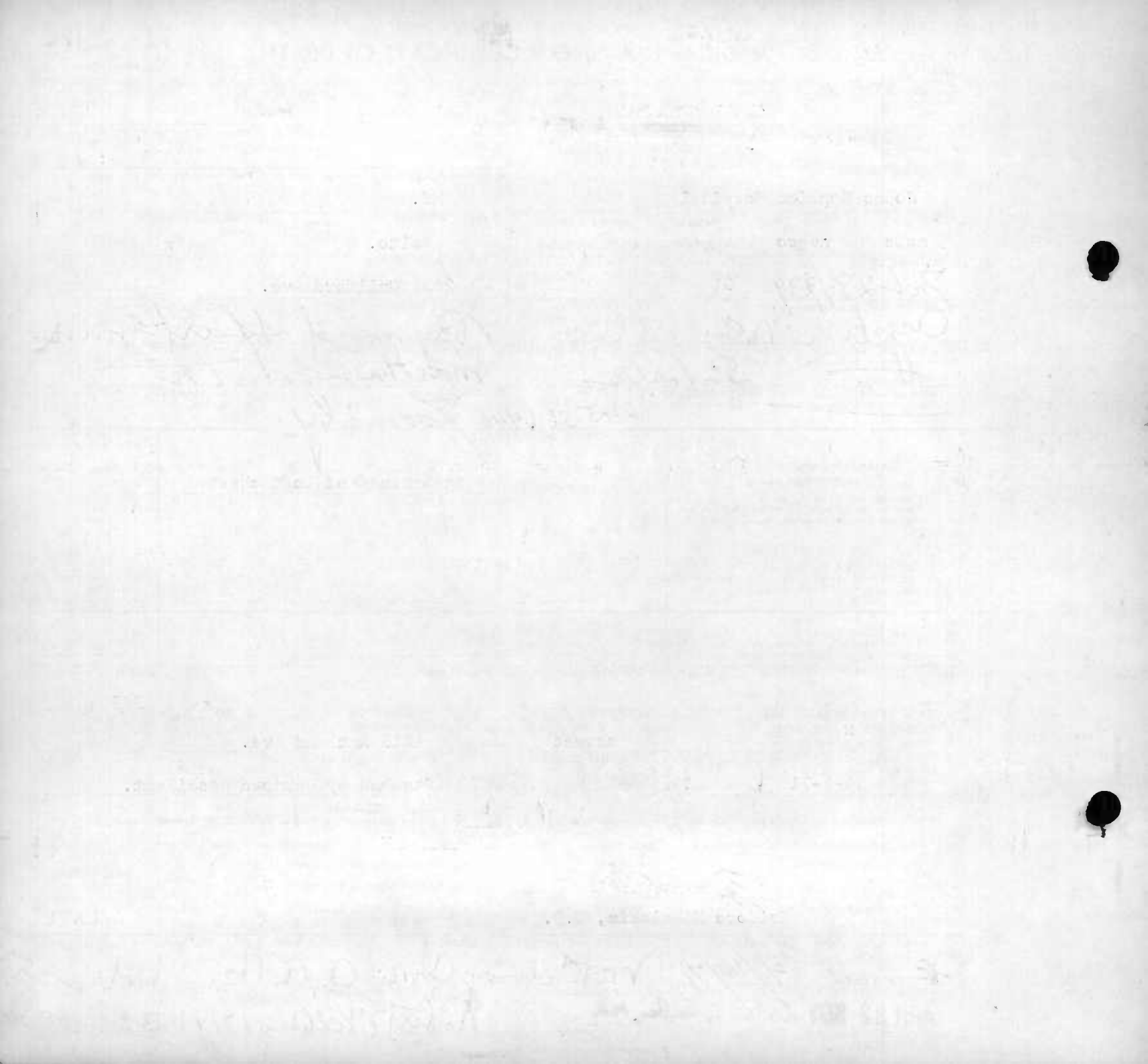
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3971	
BIRTH NO. 71 3971		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Necola Barber			2. DATE AND HOUR OF DEATH April 8, 1971 3:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1401		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Grosvenor Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1752 Park Avenue		
5. SEX F	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/8/09	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker		10B. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Milton Cox		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 242-14-5335		17. INFORMANT Joseph Carroll Balt. Md.	
18. 470.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/16/70 19 to 2/27/71 19, and that (I) (we) lost saw the deceased alive on 2/27/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4/13/71	
23C. PHYSICIAN'S NAME (Type) HOLLIS DEUNALINE MD		23D. ADDRESS 1801 Greenberry Rd Balt. Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/71		24C. NAME of CEMETERY or CREMATORY Black Bottom Cem	
24D. LOCATION (City, town, or county) (State) Bel Haven, N.C.		25A. DATE REC'D BY HEALTH DEPT. APR 23 1971			
25B. NAME OF REGISTRAR R. E. Barber, Md.		25C. FUNERAL DIRECTOR J. B. Johnson			
25D. ADDRESS 1900 E. E. St. Balt. Md					



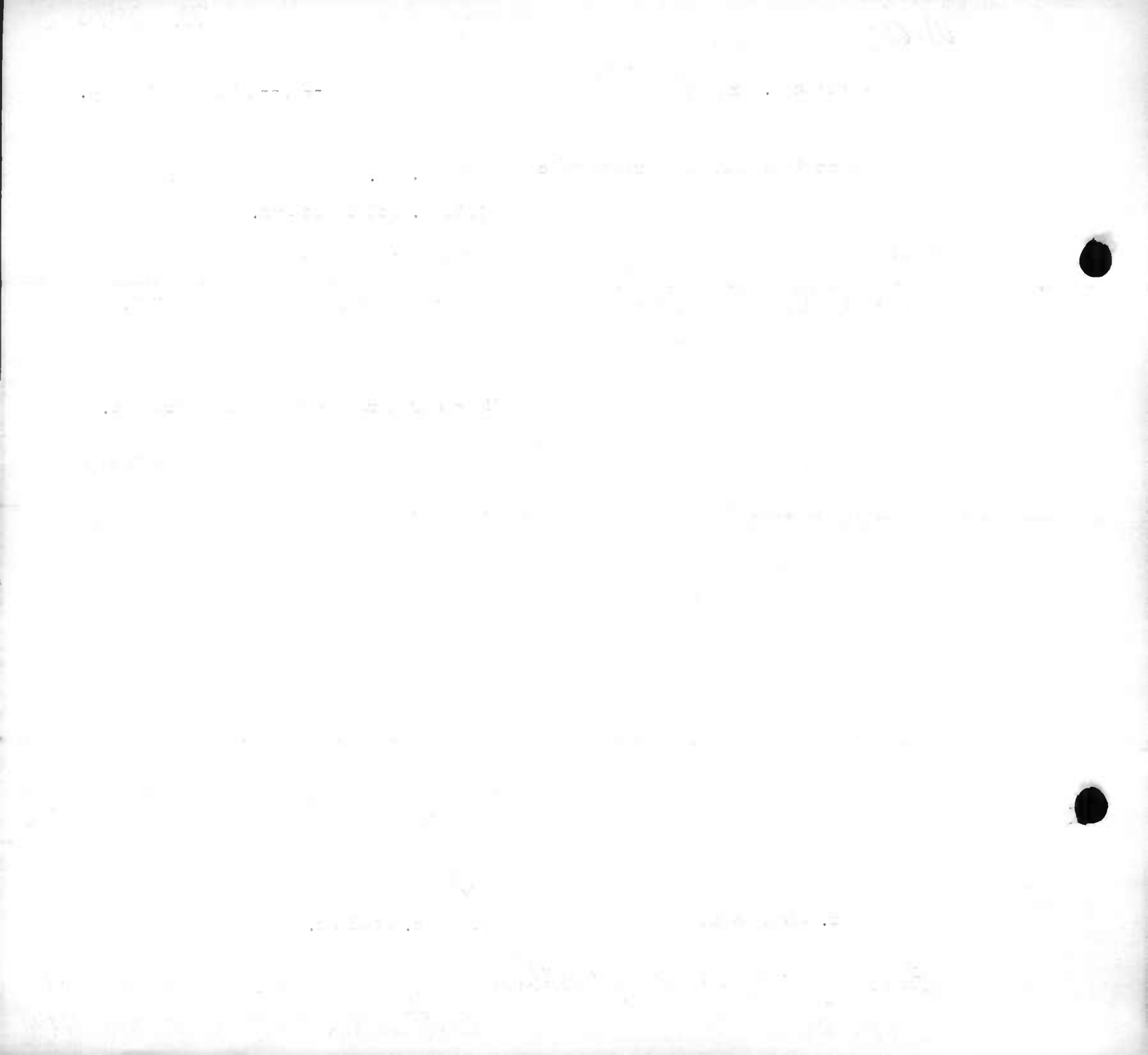
71 3972				BALTIMORE CITY HEALTH DEPARTMENT				71 3972			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								REG. NO.			
1. NAME OF DECEASED (Type or Print) RONALD SPARKMAN								2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital								3. DATE PRONOUNCED DEAD Month Day Year Hour 4 9 1971 9:50 p.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1203											
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH Jul 28 1937		10. AGE (In years last birthday) 31		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2532 Guilford Ave.					
11. BIRTHPLACE (State or foreign country) Oregon, U.S.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Raymond Sparkman		14. USUAL OCCUPATION (Give kind of work, even if retired) Stalor		15. MOTHER'S MAIDEN NAME Martha Smith			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 245-566440		18. INFORMANT Family		ADDRESS					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).								(A) IMMEDIATE CAUSE Stab wound of left chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION 2								20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-9-71 ? m.								22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1215 Rutland Ave. 1203								22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.								CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/10/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/71		24C. NAME OF CEMETERY or CREMATORY Wm Calvary Cem.		24D. LOCATION (City, town, or county) (State) AA Co. Md					
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Robert Williams		ADDRESS 1701 N Bond St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

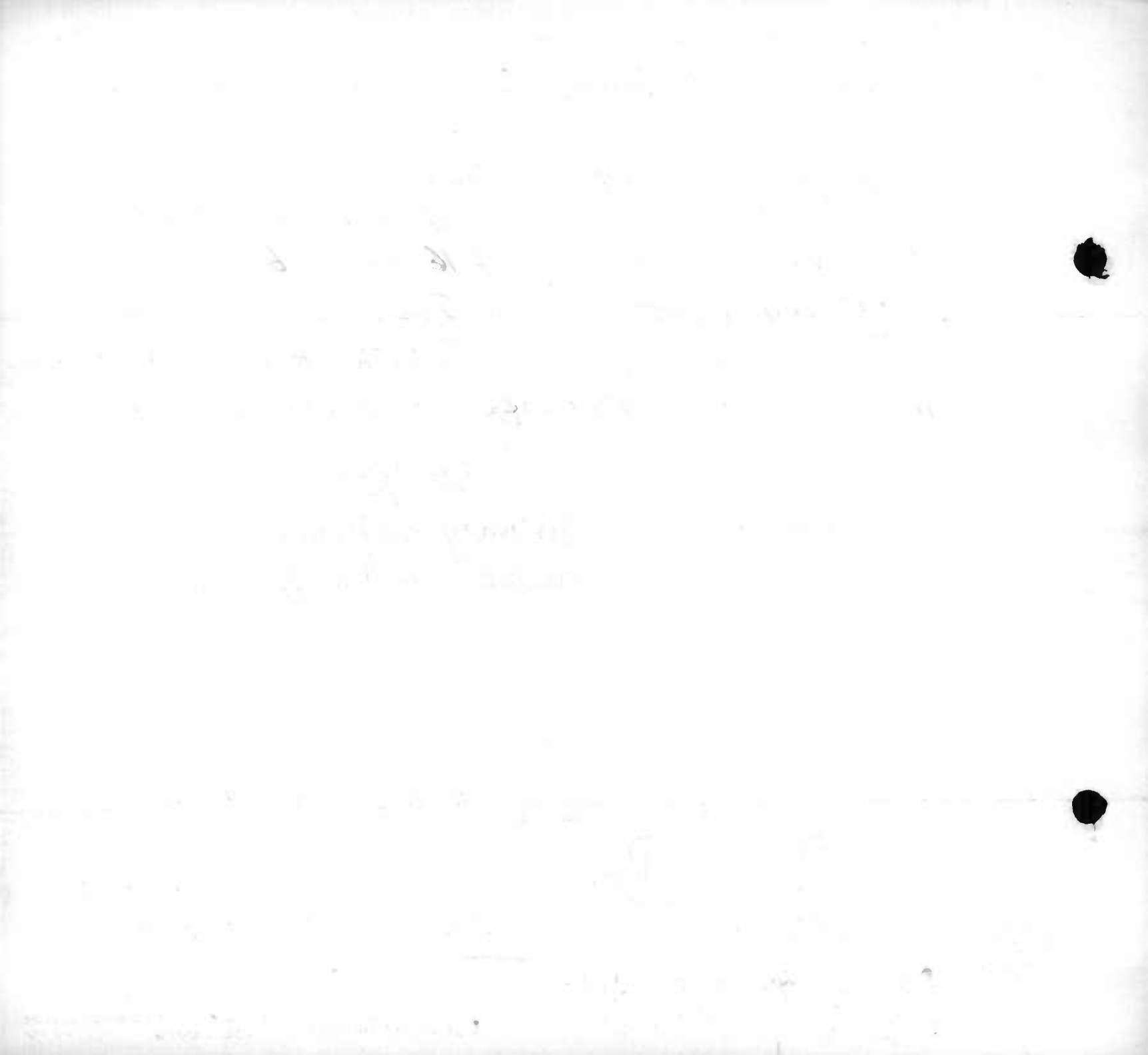
BALTIMORE CITY HEALTH DEPARTMENT				71 3973
71 3973 CERTIFICATE OF DEATH				REG. NO. _____
1. NAME OF DECEASED (Type or Print) APOLLINE M. WRIGHT		2. DATE AND HOUR OF DEATH 4--18--1971 p.m M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in the Pines Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____		
5. SEX Female	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1891	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prof. Musician - Homemaker		11. BIRTHPLACE (State or foreign country) Mercer, Pa.		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Smith		14. MOTHER'S MAIDEN NAME Not Available		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Tacoma Funeral Home
18. 7 3 7 0 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension		2 yrs.
(C) _____				> 2 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Feb 19 70 to April 18 1971 that (I) (we) last saw the deceased alive on April 16 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Alan B Cohen		23B. DATE SIGNED 4/19/71		
23C. PHYSICIAN'S NAME (Type) Dr. Alan Cohen		23D. ADDRESS 3501 St. Paul St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/21/1971	24C. NAME of CEMETERY or CREMATORY George Washington Cemetery	24D. LOCATION (City, town, or county) (State) Adelphi Pr. Dis. Md	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971	25B. NAME OF REGISTRAR John E. Walters	25C. FUNERAL DIRECTOR Tacoma Funeral Home	25D. ADDRESS 254 Carroll St. N.W.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420 71 3974				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3974	
1. NAME OF DECEASED (Type or Print) BAYLES, MARIANNE C				2. DATE AND HOUR OF DEATH 7-20-71 9:45 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1607			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore, Md #16		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1501 N. DuKeland, St.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-16-95	9. AGE (in years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) ILL.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Cassidy				14. MOTHER'S MAIDEN NAME Judith Ann LaForge			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 57830894		17. INFORMANT Judith Burke ADDRESS Wash 4107 Md. Ave D.C.			
18. 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hyperpyrexia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary infection diabetes Chr Brain Syndrome				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-11 19 71 to 4-20 19 71 that (I) (we) lost saw the deceased alive on 4-20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R Govind Rao				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-20-71	
23C. PHYSICIAN'S NAME (Type) Dr. R. Govind Rao				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE April 22 1971		24C. NAME OF CEMETERY or CREMATORY CEDAR HILL		24D. LOCATION (City, town, or county) (State) SUITLAND, MD	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert A. Kelley		25C. FUNERAL DIRECTOR Walter A. Kelley ADDRESS 4748 Wisconsin Ave NW 20016			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-365 71 3975		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 3975	
1. NAME OF DECEASED (Type or Print) STRAIN, FREDERICK Lawson			2. DATE AND HOUR OF DEATH 1140PM 4/17/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 506 ALABAMA ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-28-97	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg. Engineer-Retired			10B. KIND OF BUSINESS OR INDUSTRY Western Electric Co.		11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ISAAC STRAIN		
14. MOTHER'S MAIDEN NAME ADDIE Amison Lewis			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		
16. SOCIAL SECURITY NO. 346-09-2475			17. INFORMANT Family Records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio-Respir Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Sepsis + Renal Failure (C) 2° Operative Hypotension + 2° Ischemic Colitis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II COPD - empty sella, chronic bronchitis, BPH					
19A. DATE OF OPERATION 3/26 + 4/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH + suspected ischemic vessels		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/25 19 71 to 4/17 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1140PM 4/17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Rein Saral M.D.			23B. DATE SIGNED 4/17/71		23C. PHYSICIAN'S NAME (Type) REIN SARAL M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Apr. 20, 1971		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial Cntr., Cockeysville, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John Burns' sons, Towson, Maryland

CC 57 JAN 1953

RECEIVED JAN 1953

1953

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
71 3976		71 3976		
1. NAME OF DECEASED (Type or Print) LEHEW, BEN LYNN		2. DATE AND HOUR OF DEATH 18 APR 1971 2305 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSP.		C. CITY OR TOWN LOCHearn	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 3653 CAMPBELL AVE.				
5. SEX M	6. RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 3X DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12 JAN '04	9. AGE (in years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY Hight Co.		11. BIRTHPLACE (State or foreign country) OKLAHOMA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BEN A. LEHEW		
14. MOTHER'S MAIDEN NAME SADIE AKERS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 440-10-8983		17. INFORMANT Mrs. Fred E. Miles, 3653 Campbell St.		
18. I 1990 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC CARCINOMA UNDET. DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 10 FEB 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LAMINECTOMY T5-T6		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that the (this hospital) attended the deceased from 7 APRIL 1971 to 18 APR 1971 that the (we) last saw the deceased alive on 18 APR 1971 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.				
23A. SIGNATURE Bruce A. Mallin, M.D.		23B. DATE SIGNED 18 APR 1971		23C. PHYSICIAN'S NAME (Type) BRUCE A. MALLIN, M.D.
23D. ADDRESS 1406 PARK AVE.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE April 22, 1971		24C. NAME OF CEMETERY OR CREMATORY Highland Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		
25B. NAME OF REGISTRAR Frank A. Jewell		25C. FUNERAL DIRECTOR Frank A. Jewell		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3977

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry J. Oliver		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 18 71 11:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 18 71 11:45 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1605		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Oct 9, 1935		10. AGE (In years last birthday) 35 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Danville Va		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Oliver		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk	
15. MOTHER'S MAIDEN NAME Pearl Fulmore		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Aleene Montgomery ADDRESS 1322 Harker Ave.	
19. E966 I X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Stabwound of chest		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	
22C. WHERE DID INJURY OCCUR? 2222 Riggs Avenue		22D. TIME OF INJURY (APPROX.) Month Day Year Hour 4 18 71 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was stabbed by common law wife during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/19/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/71	
24C. NAME OF CEMETERY or CREMATORY W. Auburn Cem. Balto.		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3199 Schroeder St	

Shipping Clerk
Portland Va
Oct 1902

John Oliver
Portland, Me
New England

Superintendent

Received
\$100.00
for
the
year
1902

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

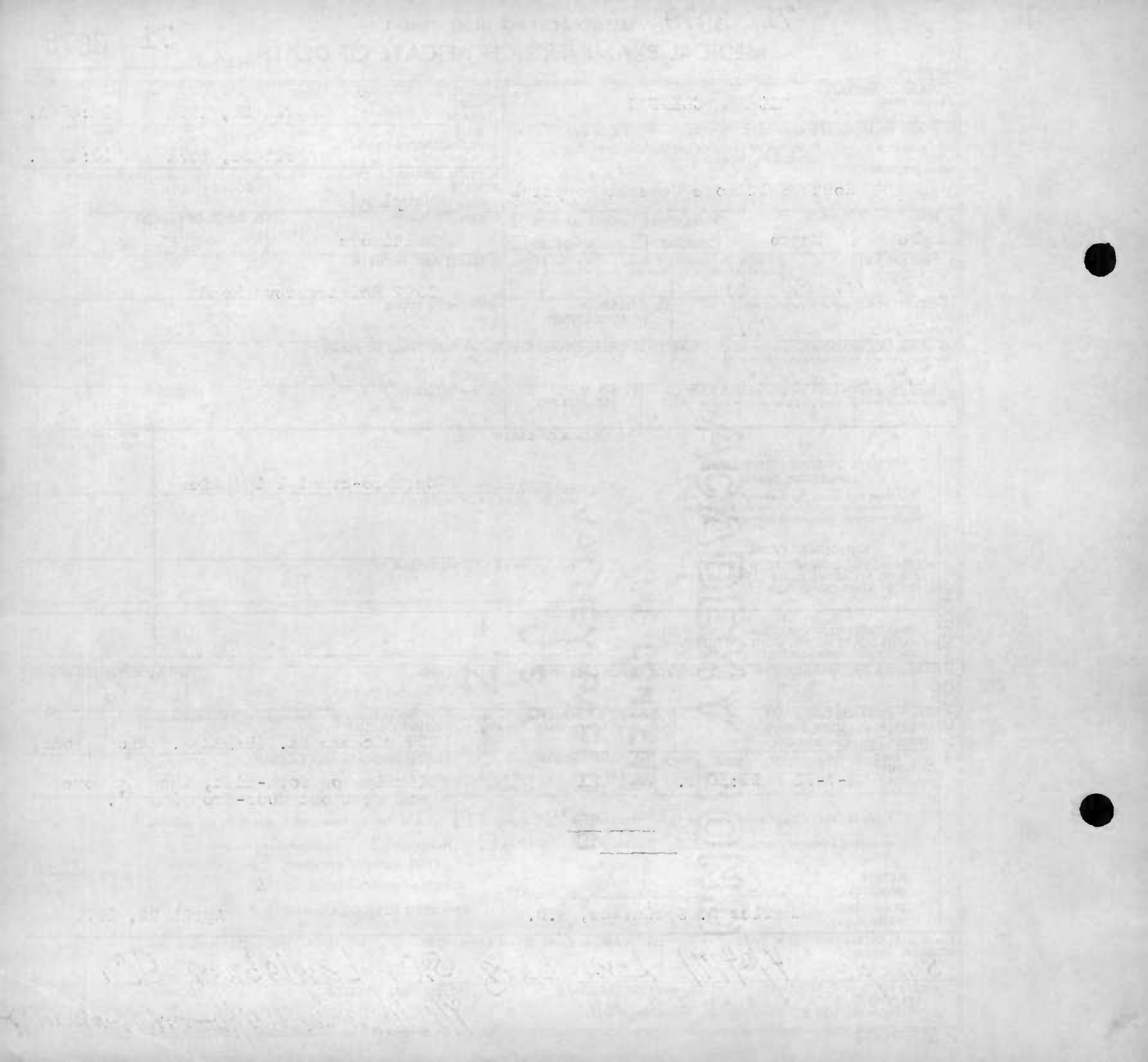
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3978	
J-525 5871 3978		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) JOHNSON, IRENE		2. DATE AND HOUR OF DEATH 4-22-71 6:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE Md. B. COUNTY 1608	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hosp of Maryland 730, ASHBURTON St. Balto 21216		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3808 Harlem Ave.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		8. DATE OF BIRTH 9-29-14 9. AGE (In years lost birthday) 56	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME Jack Carter		12. CITIZEN OF WHAT COUNTRY? U.S.A	
14. MOTHER'S MAIDEN NAME Irene Mason		17. INFORMANT Joseph Johnson 3808 Harlem Ave.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/17 1971 to 4/22 1971 that (I) (we) last saw the deceased alive on 4-22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE C. GAKUBA		23B. DATE SIGNED 4-22-71	
23C. PHYSICIAN'S NAME (Type) C. GAKUBA		23D. ADDRESS Lutheran Hosp 730, ASHBURTON St. Balto 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		24D. LOCATION Balto Md	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Williams Funeral Home 397 N. Howard St		ADDRESS	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

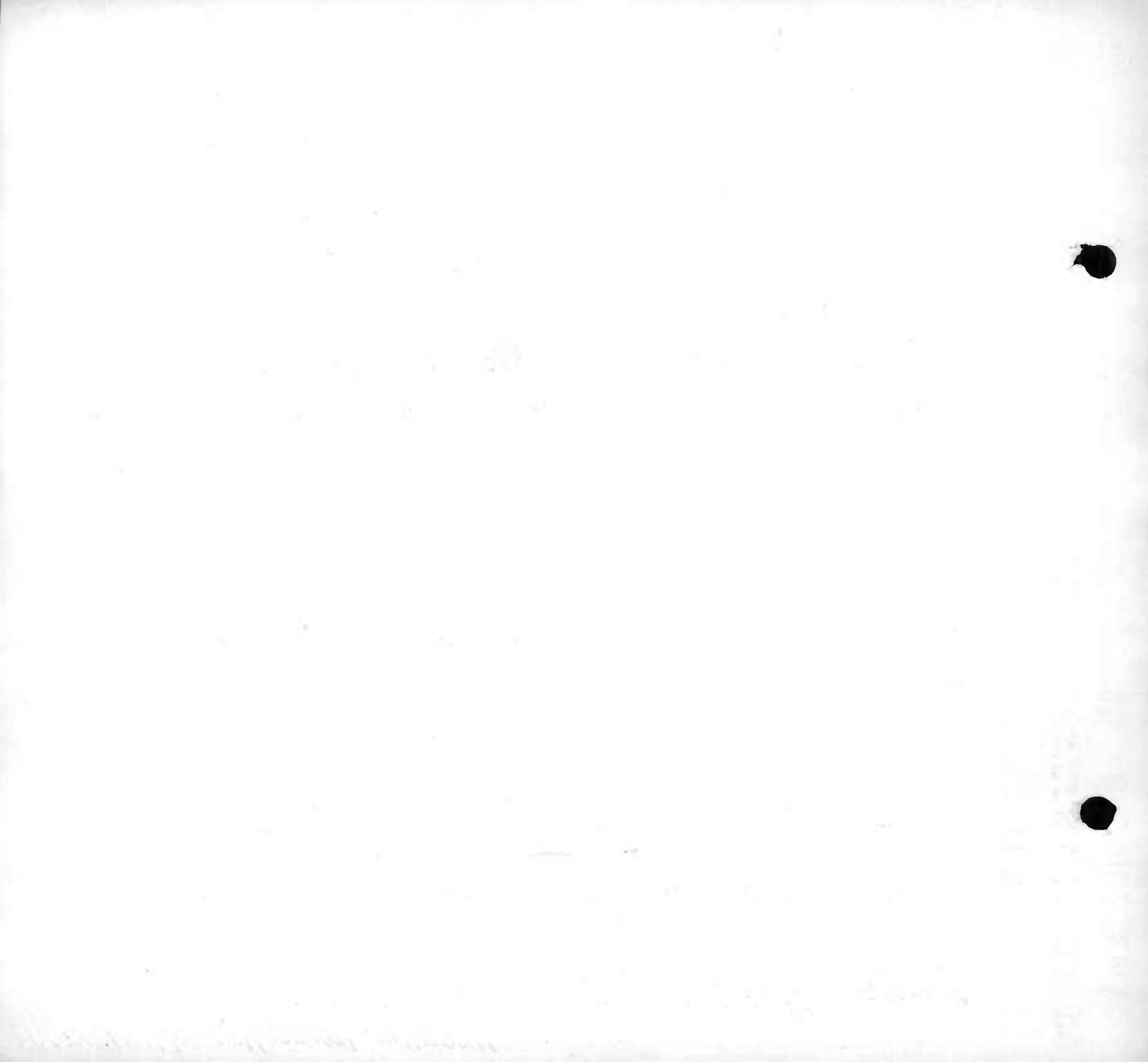
1. NAME OF DECEASED (Type or Print) RICHARD CLIFTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 21, 1971 Hour 10:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour April 21, 1971 10:45 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1512		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 13, 1950		10. AGE (In years last birthday) 20	
11. BIRTHPLACE (State or foreign country) Lewisburg, N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nathaniel Clifton		14. MOTHER'S MAIDEN NAME Carrie Nicholson	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fork Lift Driver		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO.	
19. E-884 X		19. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2303 250 Dickman St. (Frank A. Serio & Sons)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4-7-71 11:30 P.M.	
22E. INJURY OCCURRED <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Climbing on fork-lift, when it moved and went out door-dropping 6'.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 4/24/71	
24C. NAME OF CEMETERY or CREMATORY Lewisburg S.C.		24D. LOCATION (City, town, or county) (State) Lewisburg S.C.	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR William J. Turner		25D. ADDRESS Home 322 N. Howard St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

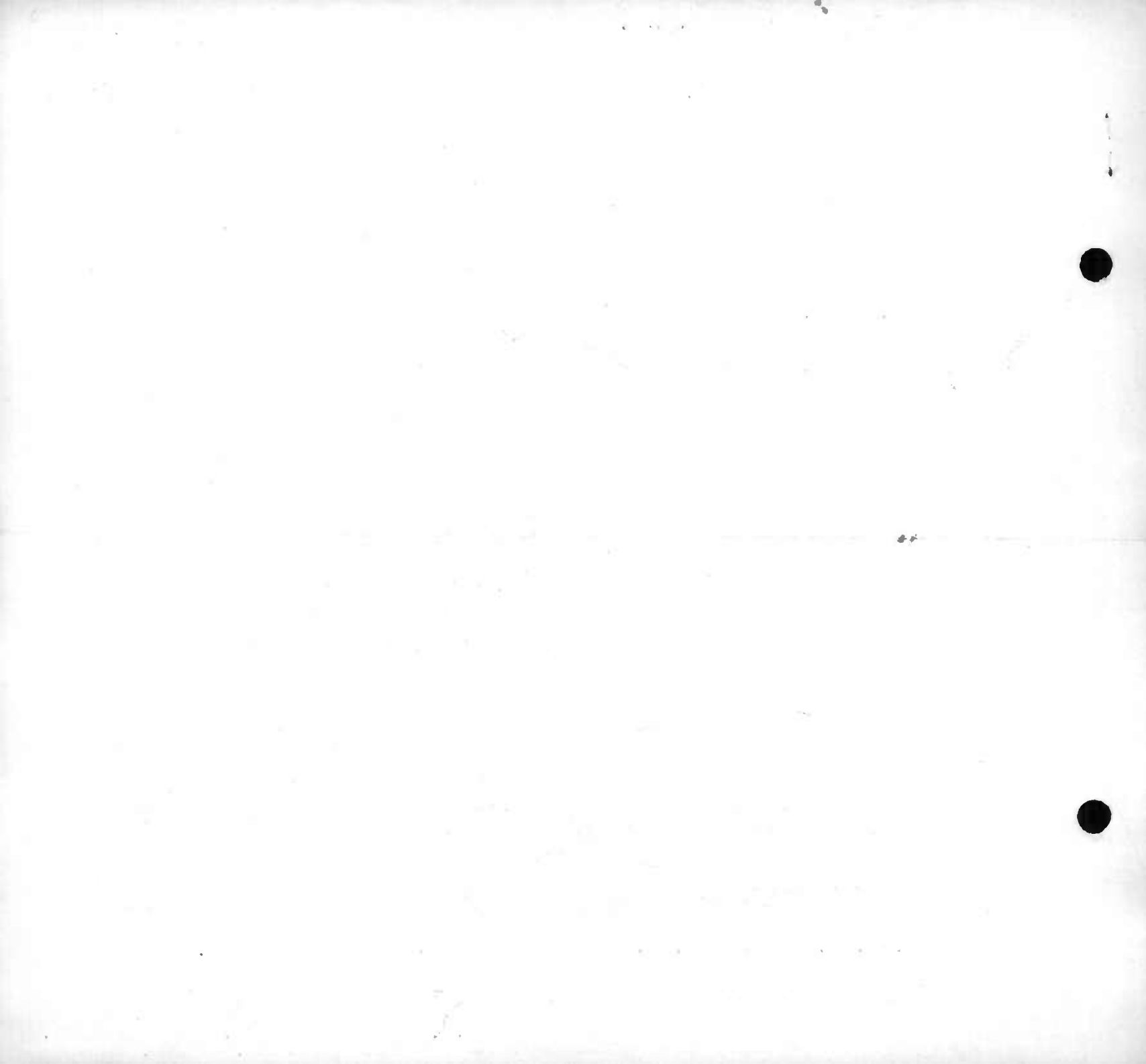
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3980</u>	
J-250 <u>71 3980</u>		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ethel Jackson</u>		2. DATE AND HOUR OF DEATH <u>April 20, 1971</u> <u>3:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mount Sinai Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>806 W. Lexington St.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-93</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. <input type="checkbox"/> If Under 24 Hrs. <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Buford S.C.</u>	
13. FATHER'S NAME <u>Joseph Haze</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bryson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or doles of service <u>No</u>		16. SOCIAL SECURITY NO. <u>2 15-10-007D</u>		17. INFORMANT <u>Benjamin Haze Jr.</u> ADDRESS <u>8503 Wilkesboro Lane</u>	
18. <u>15-381</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>1) Anemia 2) Rectovaginal Fistula 3) ASHD 4) Diabetes mellitus</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 9</u> 19 <u>71</u> to <u>April 20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 19</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry J. Babitt, M.D.</u>		23B. DATE SIGNED <u>April 20, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Henry J. Babitt, M.D.</u>	
23D. ADDRESS <u>4623 Hawksbury Rd Balt., Md</u>		23E. DEGREE <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/26/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>W. Auburn Cem.</u>	
24D. LOCATION <u>Balto.</u>		24E. LOCATION (City, town or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>William's Funeral Home</u>	
25D. ADDRESS <u>3971 Wilkesboro Lane</u>					



FUNERAL DIRECTOR: IMPORTANT

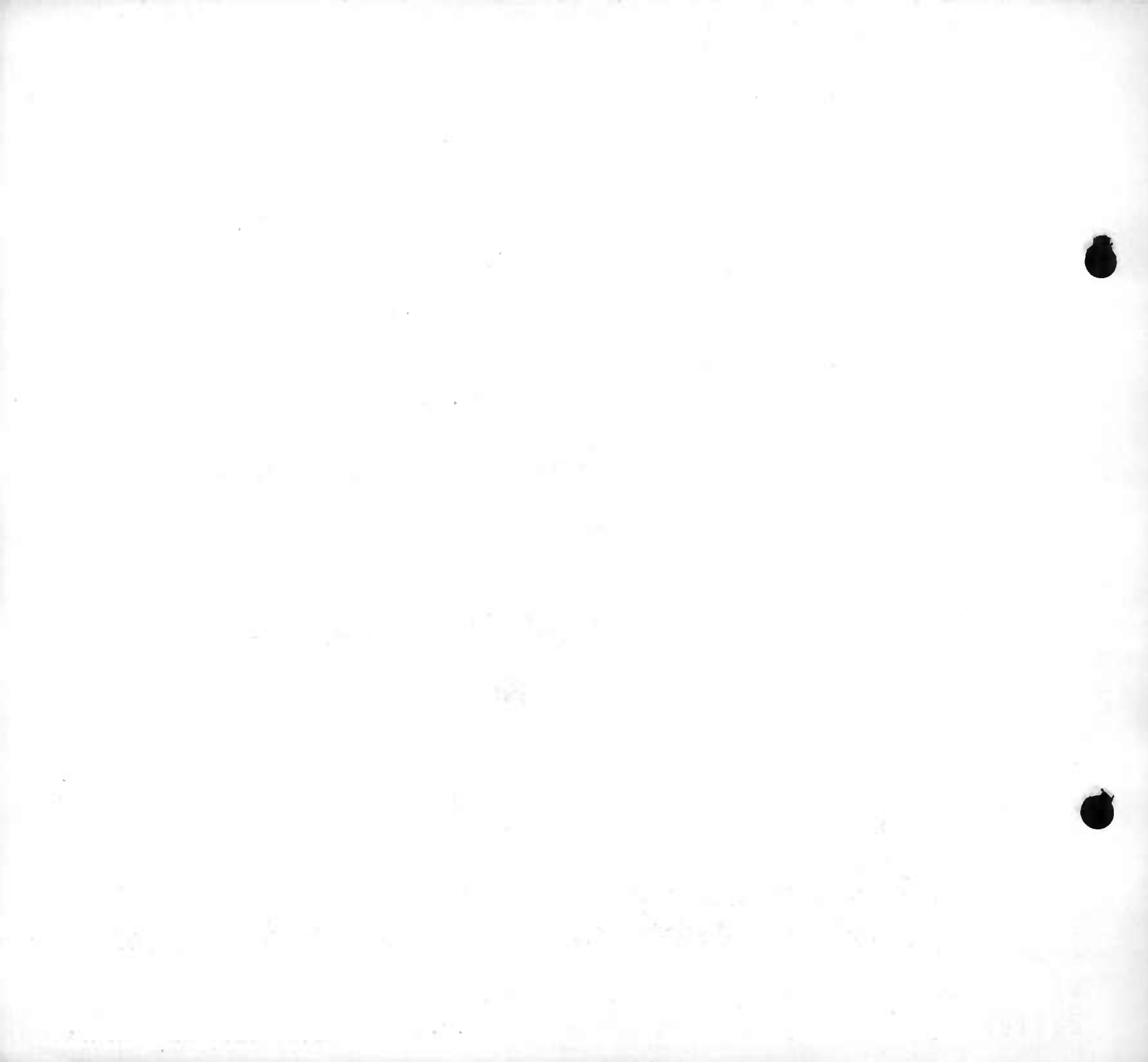
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-520		71 3981		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3981	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
Sada L. Funk				2. DATE AND HOUR OF DEATH April 22, 1971 6:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.			
00 3405 Greenway Apt. 3 F				B. COUNTY 1202			
5. SEX F				6. RACE W			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3-11-1884			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (in years last birthday) 97			
Ret. Acct.				10B. KIND OF BUSINESS OR INDUSTRY Self Employed			
11. BIRTHPLACE (State or foreign country) Kentucky				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George W. Funk				14. MOTHER'S MAIDEN NAME Letitia Hickman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Rebecca Funk				ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (General description) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary congestion & pneumonia Acute myocardial insufficiency Ophthalmic Shingles 6 months ago			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years 8 days 3 days							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) no				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 8 days				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 3405 Greenway			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3405 Greenway				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) fall -			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? Fall down			
22. I certify that (I) (this hospital) attended the deceased from 12/4 1966 to 4/22/71 that (I) (we) last saw the deceased alive on 4/22/71 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M.B. Levin				23B. DATE SIGNED 4/22/71			
23C. PHYSICIAN'S NAME (Type) Dr. M. B. Levin M. D.				23D. ADDRESS 218 E. University Pkwy.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation				24B. DATE 4-26-71			
24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971				25B. NAME OF REGISTRAR Robert E. Talley, R.D.			
25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.				ADDRESS 4905 York Rd. Baltimore, Md. 21212			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3982	
BIRTH NO. M-232 71 3982		1. NAME OF DECEASED (Type or Print) Emma L. McCutcheon			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Edgewood Nursing Home		2. DATE AND HOUR OF DEATH 8:30 pm 4-22-71 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2739 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1427 Stonewood Rd. 21212			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-16-1898	9. AGE (in years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book keeper		10B. KIND OF BUSINESS OR INDUSTRY Gunther Hardware		11. BIRTHPLACE (State or foreign country) Balto., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert L. McCutcheon			
14. MOTHER'S MAIDEN NAME Emma Grace Parker		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marion Carpenter 60 Verstreet Dr. Rochester, New York			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-11-70 </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE Cerebral Thrombosis - multiple - DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (C) DUE TO, OR AS A CONSEQUENCE OF: </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Benign Gastric Ulcer - multiple Diverticulosis -					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-10 1971 to 4/22 1971 that (I) (we) last saw the deceased alive on 4-22 1971 and that in (my) (our) opinion death occurred on the date 4-22 1971 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anthony F. Carozza				23B. DATE SIGNED 4-22-71	
23C. PHYSICIAN'S NAME (Type) Anthony F. CAROZZA				23D. ADDRESS 5217 YORK RD BALTO MD 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-71		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 23 1971			
25B. NAME OF REGISTRAR Valerie E. Bailey, RD.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons 4905 York Rd. Baltimore, Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3983		71 3983			
BIRTH NO. <div style="font-size: 2em; float: left; margin-right: 10px;">6-200</div> <div style="font-size: 2em; float: left; margin-right: 10px;">71 3983</div> <div style="clear: both;"></div>				CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED <small>(Type or Print)</small> Iona May League				2. DATE AND HOUR OF DEATH 4-19-1971				7:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> 90 Gould Convalesarium				4. USUAL RESIDENCE <small>(Where deceased lived. If institution: residence before admission)</small> A. STATE Maryland B. COUNTY Baltimore				C. CITY OR TOWN Reisterstown D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 103 Danbury Road					
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-1-1883		9. AGE <small>(In years last birthday)</small> 87	
10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> Homemaker				10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE <small>(State or foreign country)</small> Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. McDaniel				14. MOTHER'S MAIDEN NAME Amanda Cover					
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> No				16. SOCIAL SECURITY NO. 220-44-2673		17. INFORMANT ADDRESS Mrs. Ervin L. Sabel 103 Danbury Rd. 21136			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: Hypertension, Coronary Artery Disease, Aortic Pulmonary edema (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral arteriosclerosis (C) <i>Stroke</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <small>(Yes or No)</small>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(Notify medical examiner)</small>		21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>					
21D. TIME OF INJURY <small>(APPROX.)</small>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 5, 1970 to April 19, 1971 that (I) (we) last saw the deceased alive on April 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Donald W. Mintzer				23B. DATE SIGNED April 22, 1971					
23C. PHYSICIAN'S NAME <small>(Type)</small> Dr. Donald W. Mintzer				23D. ADDRESS 3009 Evergreen Ave.					
24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> Burial		24B. DATE 4-23-71		24C. NAME OF CEMETERY OR CREMATORY Baltimore		24D. LOCATION <small>(City, town, or county)</small> <small>(State)</small> Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.				ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3984</u>	
BIRTH NO. <u>4-535 71 3984</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HAZEL HINTON</u>		2. DATE AND HOUR OF DEATH <u>APRIL 20-71 6 P M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2047</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>137 S. MONASTERY AVE.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-50</u>	9. AGE (in years last birthday) <u>20</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Pitt County N.C.</u>	
13. FATHER'S NAME <u>James Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Helen Barnes</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes, give war or doles of service</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Michael Hinton</u> ADDRESS <u>137-S. Monastery</u>	
18. <u>67391</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Pulm. Embolism</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Delivery</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from <u>4-19</u> 19 <u>71</u> to <u>4-20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>6 PM 4-20</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>O. J. Kim M.D.</u>		23B. DATE SIGNED <u>4-20-71</u>		23C. PHYSICIAN'S NAME (Type) <u>OK J. Kim M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-24-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbustus Memory</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md</u>		24E. NAME OF REGISTRAR <u>Morton Dyett F.H. 1701-Laurens</u>		24F. FUNERAL DIRECTOR ADDRESS <u>SP</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 23 1971</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

General (1894) for the Hon. Sec. of War
Washington, D.C. 20315

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71	3985	C-635	
BIRTH NO.				71 3985			
1. NAME OF DECEASED (Type or Print)				COURTNEY MY Thomas C			
2. DATE AND HOUR OF DEATH				4/23/71 12:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
48 MGH				Md 2717			
5. SEX				6. RACE			
M C				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH				9. AGE (In years last birthday)			
1-1-23				48			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Painter				Md. Drydock, Fnd			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Alabama				Clinton U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Courtney				Annie Courtney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
213-28-5749				Face sheet			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Intercerebral Bleed			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Hypertensive Cardiovascular Disease			
II				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19A. DATE OF OPERATION			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from 4-22-71 to 4-23-71 that (I) (we) last saw the deceased alive on 4-23-71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Manejwala				4/23/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MAVEJWALA				MGH			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				4/27/71			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Western Star Cemetery				Catonsville, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
APR 23 1971				Morton & Dyett Funeral Home 1701 Laurens St. Balto., Md. 21217			

1

71 3986 BALTIMORE CITY HEALTH DEPARTMENT 71 3986

W-426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JACK WILKERSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 21 1971 8 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4 75		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 75		E. STREET AND NUMBER 1742 N. Chester St.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. H. Wilkerson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Tech.	
15. MOTHER'S MAIDEN NAME A. Mendez Stevens		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 241-03-0586		18. INFORMANT Life 1509-28 St S.E. DC. 20020	
19. 4/12/71		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 4/12/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4, 24, 71	
24C. NAME OF CEMETERY or CREMATORY Int. Annapolis		24D. LOCATION (City, town, or county) (State) Balto City Md	
25A. DATE REC'D BY HEALTH DEPT. APR 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR William R. Carroll		ADDRESS Balto Md	

VS 151-REV. 1/1/68

1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

1. 1900

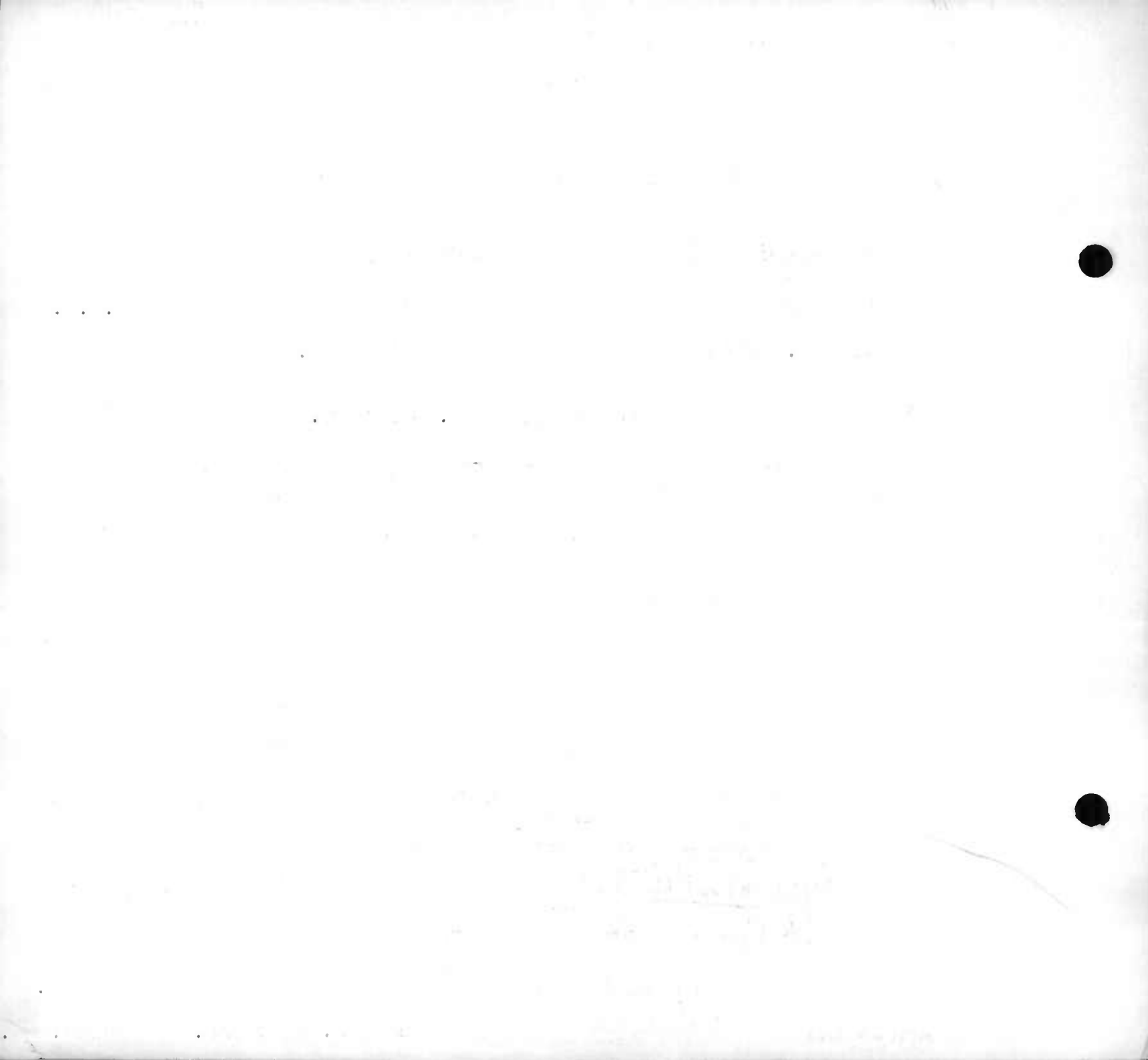
1. 1900

1. 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 3987		REG. NO. 71 3987	
CERTIFICATE OF DEATH							
BIRTH NO. E-363		1. NAME OF DECEASED (Type or Print) Edwards Ethel		2. DATE AND HOUR OF DEATH 4-22-71		2:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 904			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 628 E. 31 Street			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-08	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred W. Patton				14. MOTHER'S MAIDEN NAME Stella S. Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 28 9538		17. INFORMANT Mr. Norman T. Edwards		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia: dehydration				1 month			
(B) ANTECEDENT CAUSES DUE TO, OR AS A CONSEQUENCE OF: Ca Pancreas with metastasis				2 years			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-22 19 71 to 4-22 19 71 that (I) (we) last saw the deceased alive on 4-22 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Govinda Rao				23B. DATE SIGNED 4/22/71			
23C. PHYSICIAN'S NAME (Type) R. GOVINDA RAO				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		24D. LOCATION (City, town, or county) (State) Belair Harford Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Blair E. Kelly, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	



M-546

71 3988

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 3988

BIRTH NO.

Joseph

1. NAME OF DECEASED
(Type or Print)

ALBERT MIENL, Sr.

2. DATE
OF DEATHKnown ☐
Estimated ☐

Month Day Year Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 7 South Carey Street

3. DATE
PRONOUNCED DEAD

Month Day Year Hour

April 22, 1971 12:13 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1803

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

July 14, 1899

10. AGE (In years
lost birthday)

71

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

7 South Carey Street

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph Meinl

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Butcher

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Katherine Lehr

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.
167-12-1367

18. INFORMANT

Mrs. Doris M. Otto

5934 Clayton Ave.
Balto., Md. 2120619. 412.4
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 22, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/26/71

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

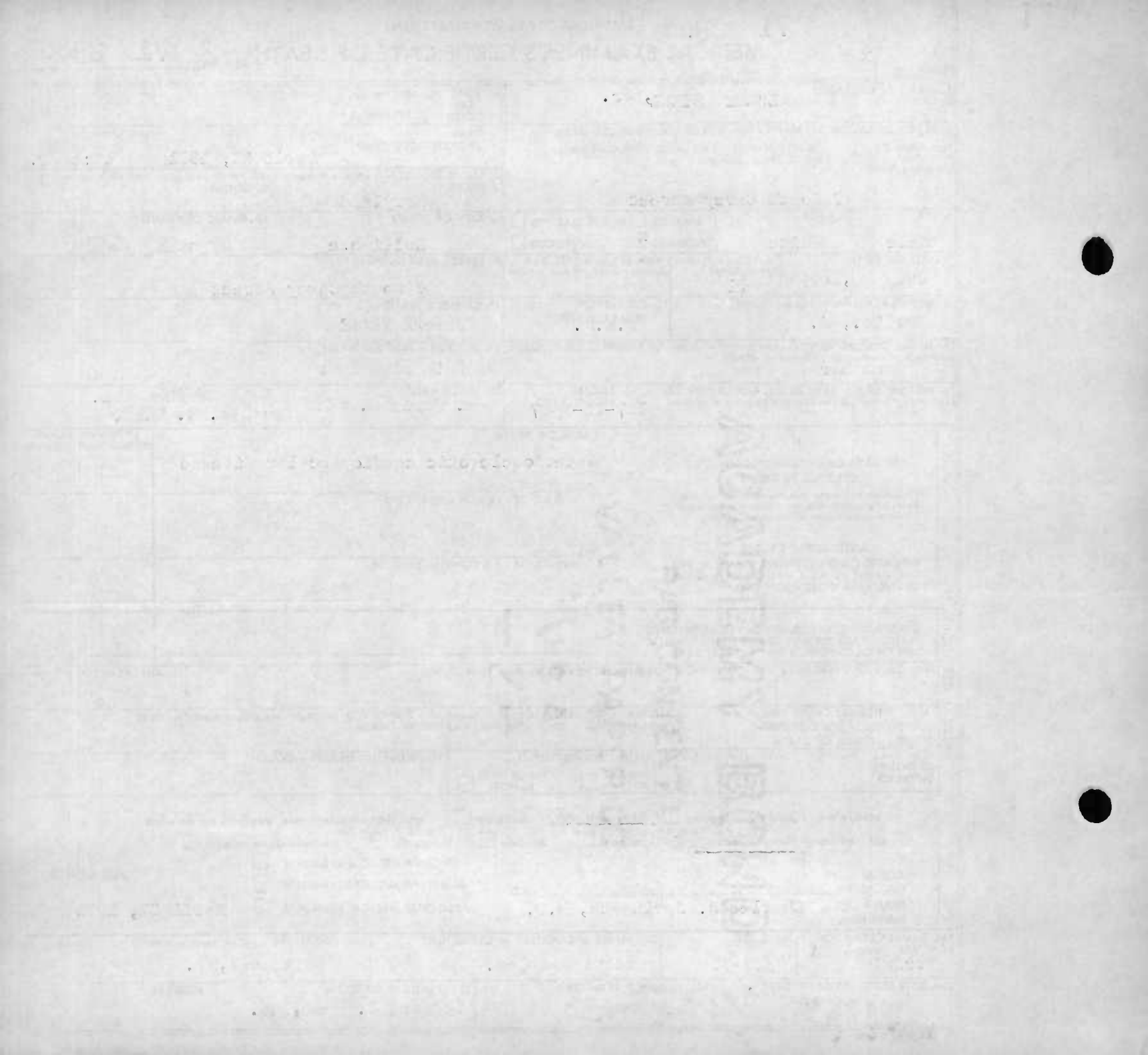
APR 26 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc.

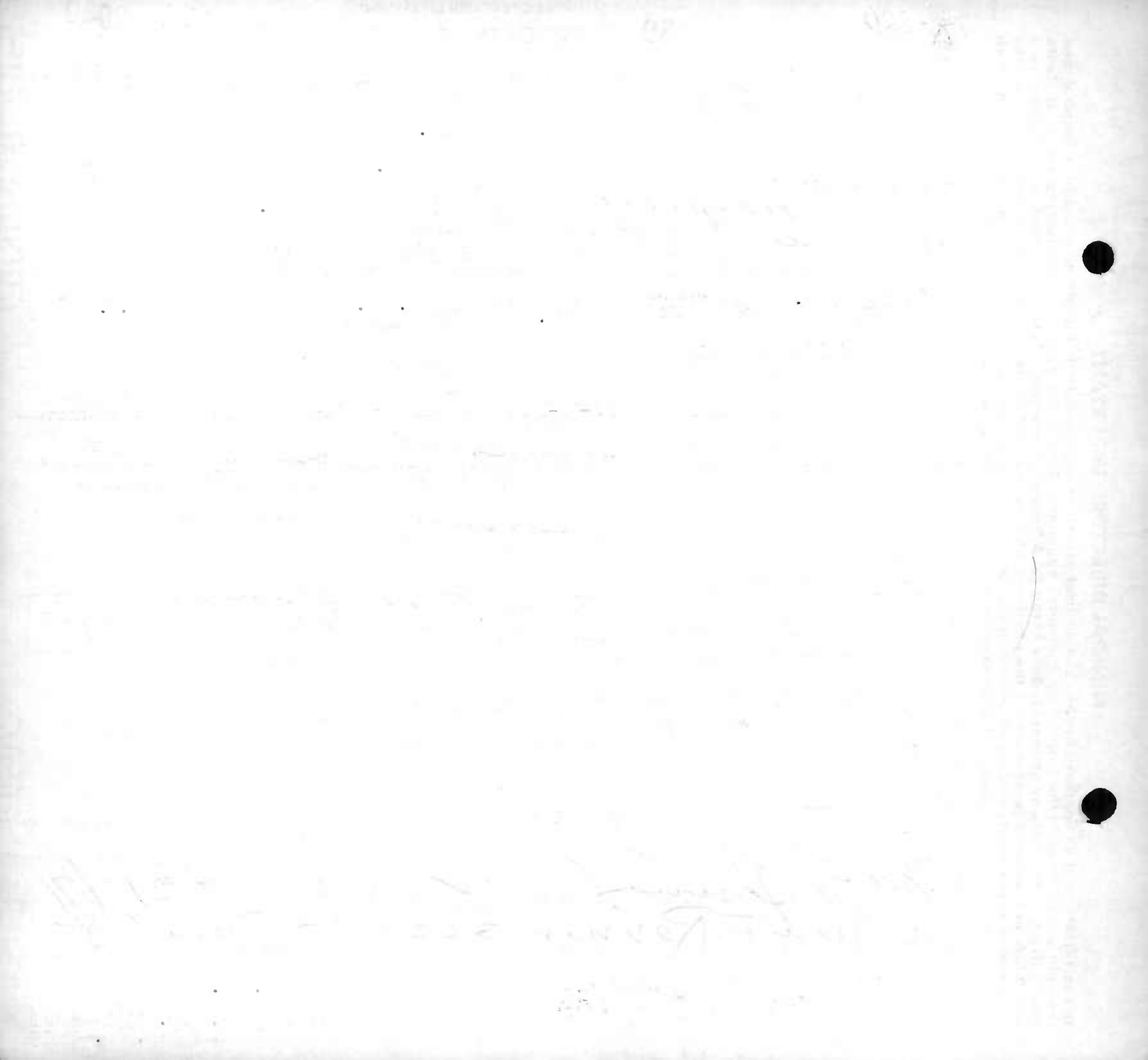
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
71 3989 CERTIFICATE OF DEATH					REG. NO. 71 3989									
BIRTH NO. <u>R-320</u>					1. NAME OF DECEASED (Type or Print) <u>Ritz Katherine</u>					2. DATE AND HOUR OF DEATH <u>4/21/71 12²⁵</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>The Union Memorial Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2633</u>					C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u>					E. STREET AND NUMBER <u>3002 Brendan Ave.</u>									
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/19/96</u>		9. AGE (In years lost birthday) <u>74</u>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flw Choc Dipper</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Virginia Dare Candy Co.</u>					11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>William Eberwein</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Fossler</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>211-12-8232</u>					17. INFORMANT <u>Edward Ritz (husband)</u> ADDRESS <u>same as above</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.94-250.7</u> [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <u>acute myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>coronary sclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute - severe sleep</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Bronchial asthma</u> <u>diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> 19 <u>71</u> to <u>4/21</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>William F. Reuner</u>					DEGREE		23B. DATE SIGNED <u>4/21/71</u>							
23C. PHYSICIAN'S NAME (Type) <u>William F. Reuner</u>					DEGREE		23D. ADDRESS <u>3222 St Paul St</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/26/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>			24D. LOCATION (City, town, or county) <u>Balto. Md.</u>			[State]				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>					25B. NAME OF REGISTRAR <u>John E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>			ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

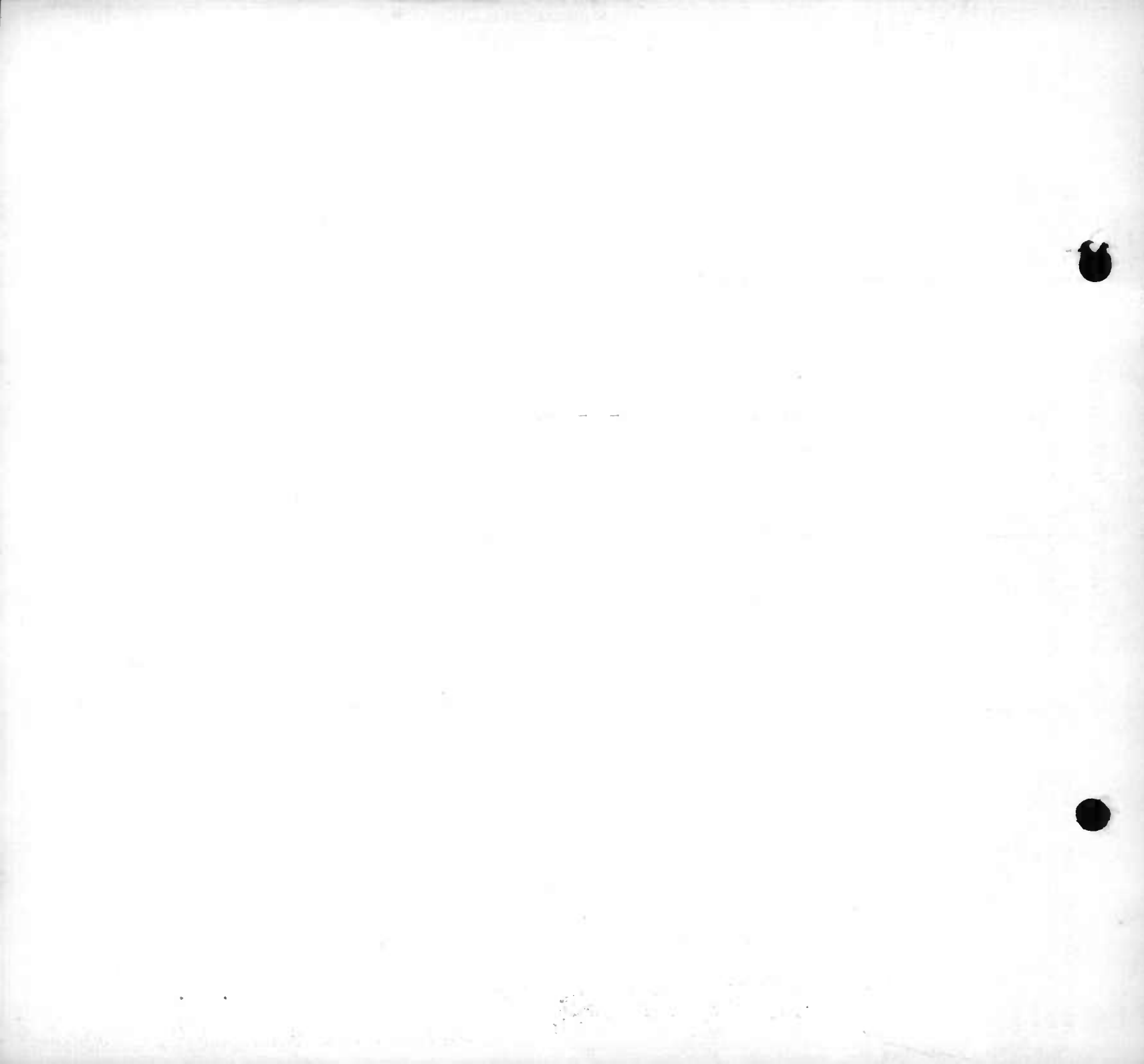
1. NAME OF DECEASED (Type or Print) John Pfeffer Pfeffer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 18 Year 71 Hour 2:00 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2508 E. Madison St.		3. DATE PRONOUNCED DEAD Month 4 Day 18 Year 71 Hour 2:00 p. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3/12/14		10. AGE (In years last birthday) 57	
11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		14B. KIND OF BUSINESS OR INDUSTRY Philip Bros.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 220-03-9907	
15. MOTHER'S MAIDEN NAME Barbara Ulrich		18. INFORMANT Margaret Karl (sister)	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/23/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR R. E. Ruby, Jr.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213		ADDRESS	

St. Lawrence

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 3991	
R-361 BIRTH NO. 1. NAME OF DECEASED (Type or Print) CHARLES H. RITTERPUSCH		2. DATE AND HOUR OF DEATH APRIL 21, 1971 10:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME S HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2610 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 209 S. East Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/15	9. AGE (in years last birthday) 55	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER		10B. KIND OF BUSINESS OR INDUSTRY STORE		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME MILTON RITTERPUSCH			
14. MOTHER'S MAIDEN NAME MATILDA WARD BY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II			
16. SOCIAL SECURITY NO. 213-10-5790		17. INFORMANT MARY E. RITTERPUSCH ADDRESS 209 E. Ave. Balt.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Chronic Renal Disease DUE TO, OR AS A CONSEQUENCE OF: Renal Failure (B) CVA, w/ hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Undetermined 1 month undetermined	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 26 19 71 to April 21 19 71 that (I) (we) last saw the deceased alive on April 21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rustum. Irani M.D. DEGREE		23B. DATE SIGNED 4/21/71		23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI M.D. DEGREE	
23D. ADDRESS CHURCH HOME AND HOSPITAL.		24A. BURIAL CREMATION, REMOVAL (Specify) burial			
24B. DATE 4/24/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR John J. ...		25C. FUNERAL DIRECTOR Schumacher Funeral Home ADDRESS 3331 ...	



FUNERAL DIRECTOR: IMPORTANT

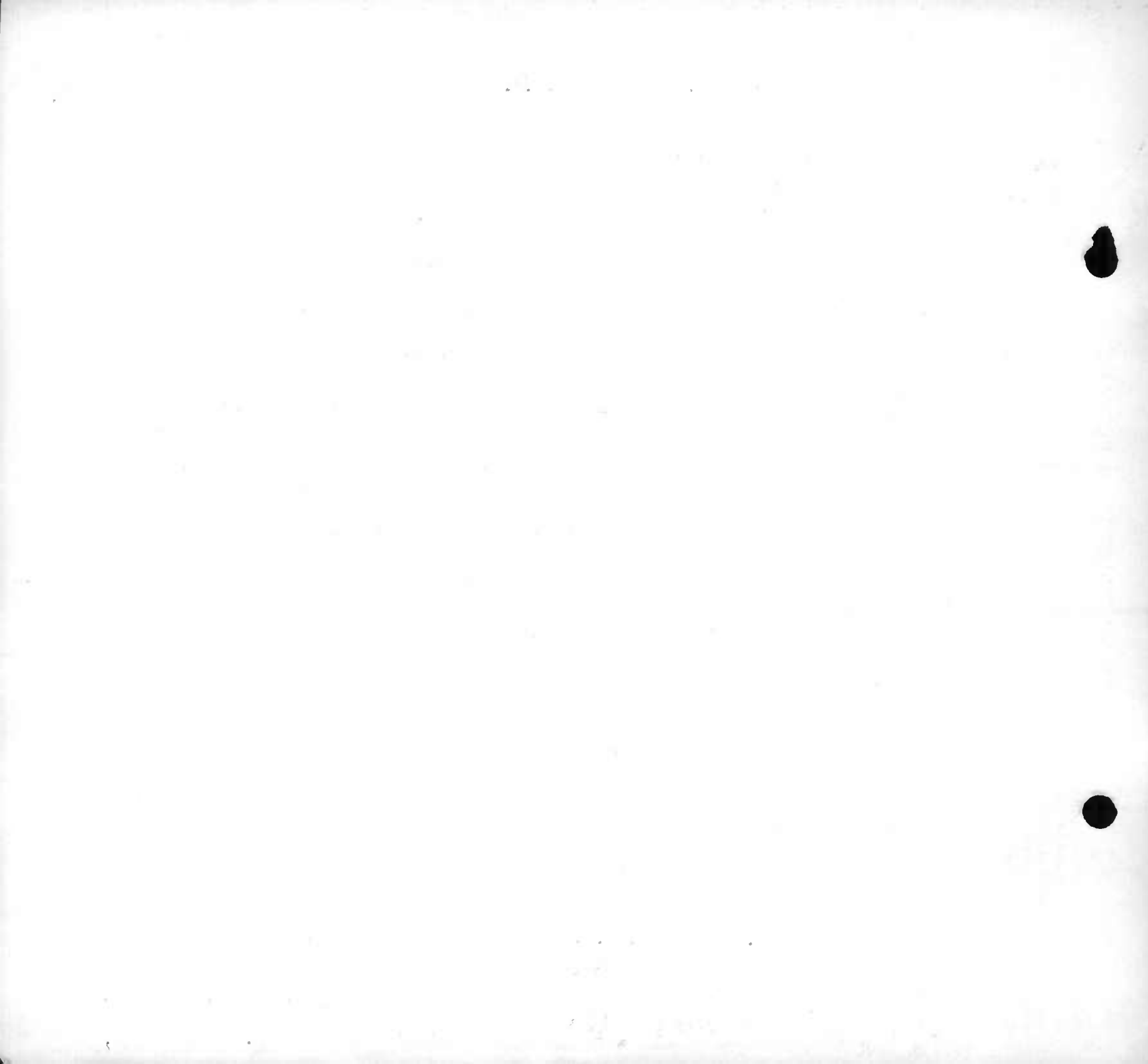
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. _____				
BIRTH NO. S-320 71 3992									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Scheetz, CALVINT.					2. DATE AND HOUR OF DEATH 4-22-71 1145 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Childrens Hospital 13845 Greenwing Ave 21211					A. STATE MARYLAND B. COUNTY BALTO. Co. 5300				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. County				
					D. STREET ADDRESS (If rural, give location) 320 Meadow Rd				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 10-27-55	9. AGE (In years last birthday) 15	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Norman Scheetz					14. MOTHER'S MAIDEN NAME Gloria E Schwartz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHIEF Mr Norman Scheetz			ADDRESS Same		
18. 330.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Muscular dystrophy INTERVAL BETWEEN ONSET AND DEATH Respiratory arrest.									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (†) (this hospital) attended the deceased from 12-15 19 69 to 4-22 19 71 , that (†) (we) last saw the deceased alive on 4-22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Kenneth C. Gertsen M.D.								23B. DATE SIGNED 4-22-71	
23C. PHYSICIAN'S NAME (Type) KENNETH C. GERTSEN M.D.				23D. ADDRESS CHILDRENS Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971			25B. NAME OF REGISTRAR Robert E. Jaber, M.D.			25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Baltimore, Md			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

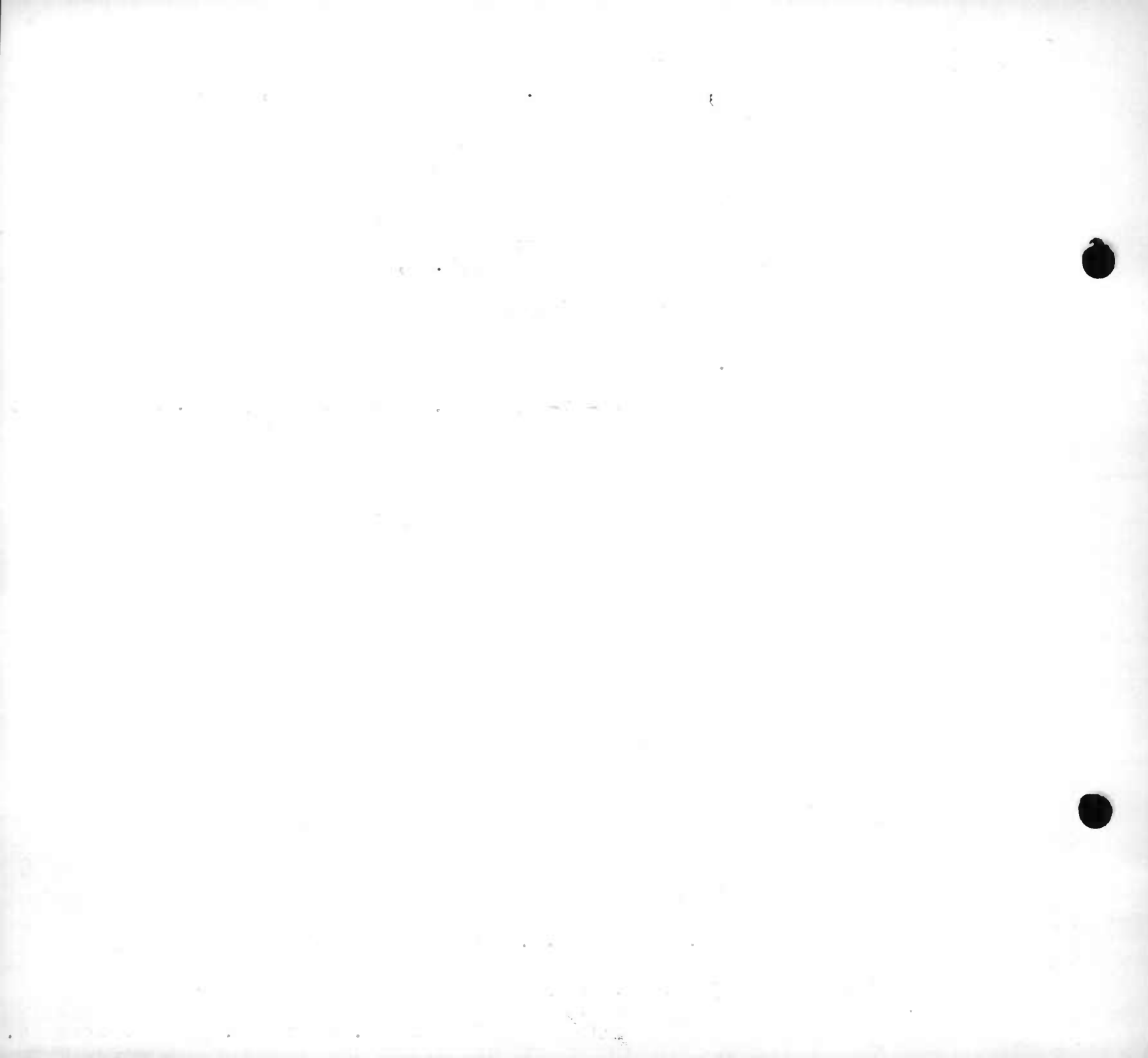
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3993	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Reverend Thomas P. McNamara, S.S.J.		April 23, 1971		9:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 19 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215		A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 911 W. Lake Avenue	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1896	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Priest		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania	
13. FATHER'S NAME Michael McNamara		14. MOTHER'S MAIDEN NAME Mary Brennan		12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 222-28-4009		17. INFORMANT ADDRESS The Seton Institute - 6400 Wabash Avenue	
18. CAUSE OF DEATH		Baltimore, Maryland		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonitis (Candida albicans infection)		3 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic myocardial degeneration DUE TO, OR AS A CONSEQUENCE OF: Vascular hypertension		?	
		(C) General arteriosclerosis and cardio-		about 8 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Cerebral arteriosclerosis with psychosis		7 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 19 1970 to April 23 1971 that (I) (we) last saw the deceased alive on April 23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrreiss, M.D.		23B. DATE SIGNED April 23, 1971		23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/71		24C. NAME of CEMETERY or CREMATORY Holy Sepulchre	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Huck Inc. Baltimore, Md	
24D. LOCATION (City, town, or county) (State) Phildelphia, Penna.		24E. ADDRESS 6400 Wabash Avenue, Baltimore, Maryland 21215			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 3994</u>	
R-163				71 3994	
BIRTH NO.				71 3994	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ROBERTO FRANK P.			APRIL 23, 1971 11 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 4502 Woodlea Avenue			Maryland 2632		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4502 Woodlea Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 6, 1906	64	11 Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Accountant		Baltimore City		USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles N. Roberto			Emily Bassett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		219-01-2835		Mrs. Emily Franke 519 N. Decker 21205	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			ASCLD with Chronic Heart Failure		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			MYOCARDIAL INFARCTION, OLD		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1968</u> to <u>April 1971</u> that (I) (we) lost saw the deceased alive on <u>9 April 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Com. H. Kammer D. OEGRE				23 April 1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William H. Kammer M.D.		6011 York Road Baltimore Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/26/71		New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 28 1971		Leonard J. Ruck Inc.		5305 Harford Rd.	

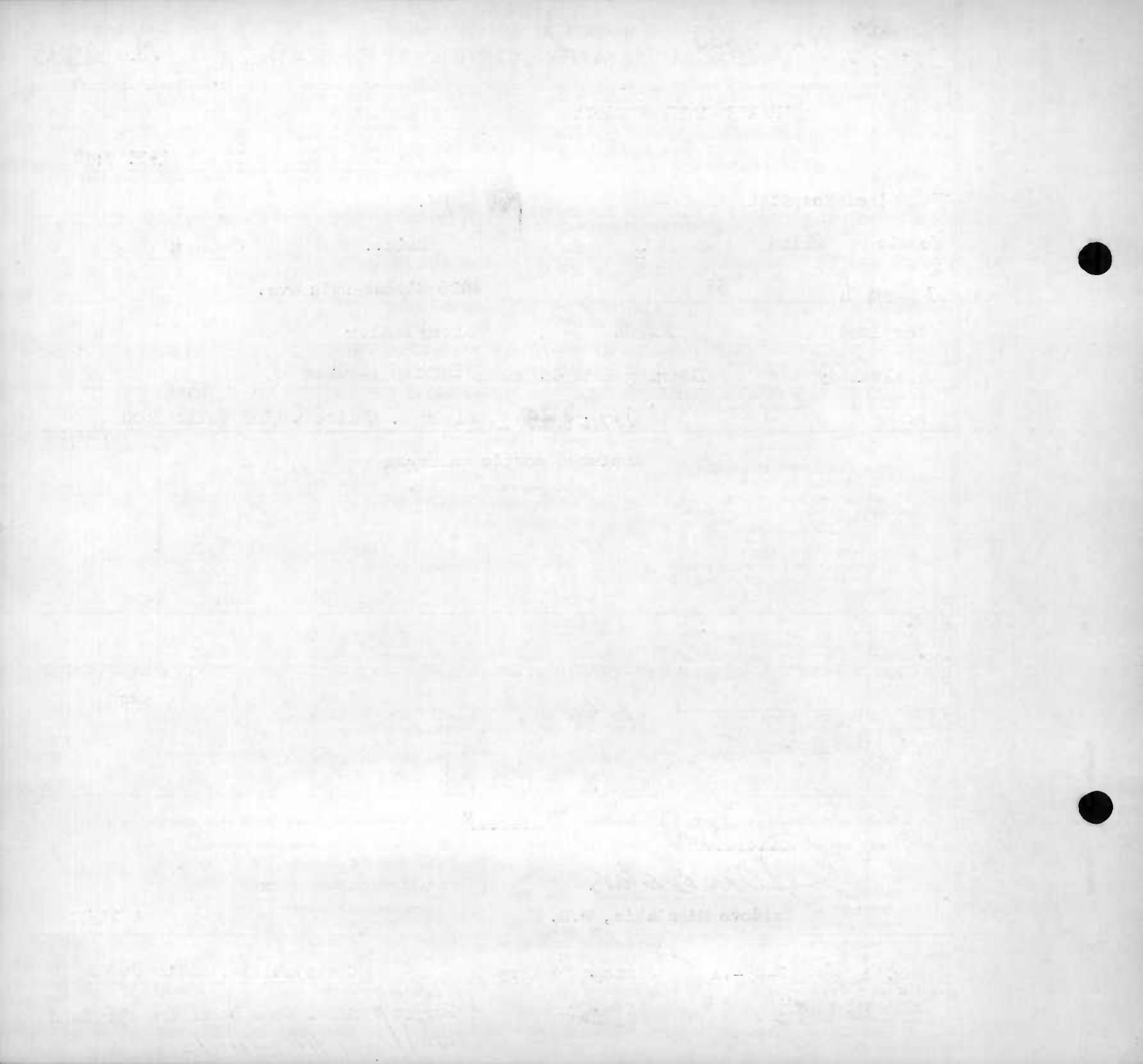


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

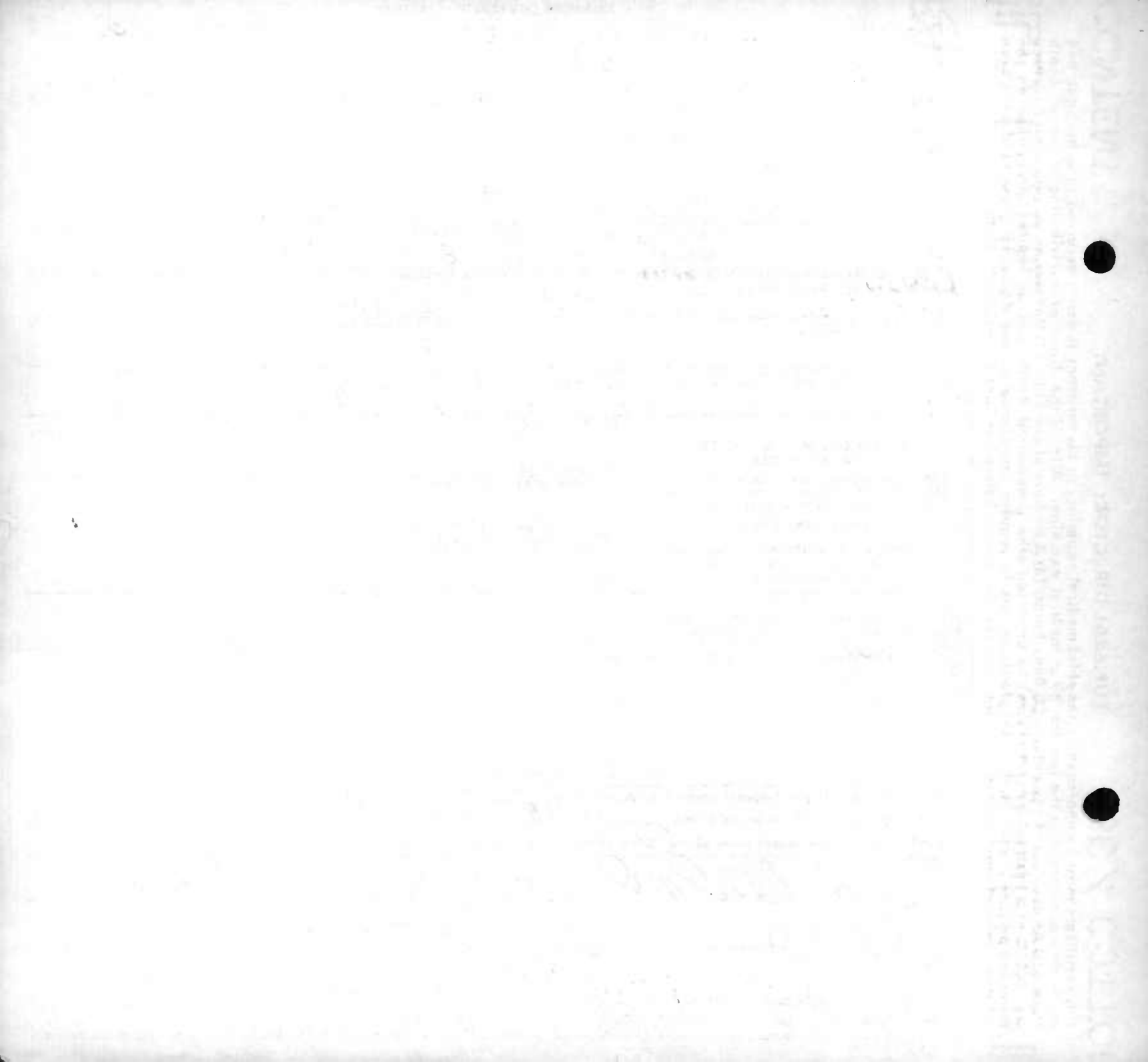
1. NAME OF DECEASED (Type or Print) MARIE ETHEL SCHERER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 20 1971 9:42 p.m.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3 Sept 01		10. AGE (In years lost birthday) 66	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Butler		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2765	
15. MOTHER'S MAIDEN NAME Catherine Bareham		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 217 03 2072		18. INFORMANT ADDRESS Melvin M. Chilcoat 4033 Falls Road	
19. CAUSE OF DEATH 4419 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ruptured aortic aneurysm ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-25-71	
24C. NAME OF CEMETERY or CREMATORY Jessops Centery		24D. LOCATION (City, town, or county) (State) Cockeysville, Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Burgee Funeral Home Baltimore Maryland		25D. ADDRESS By: [Signature]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

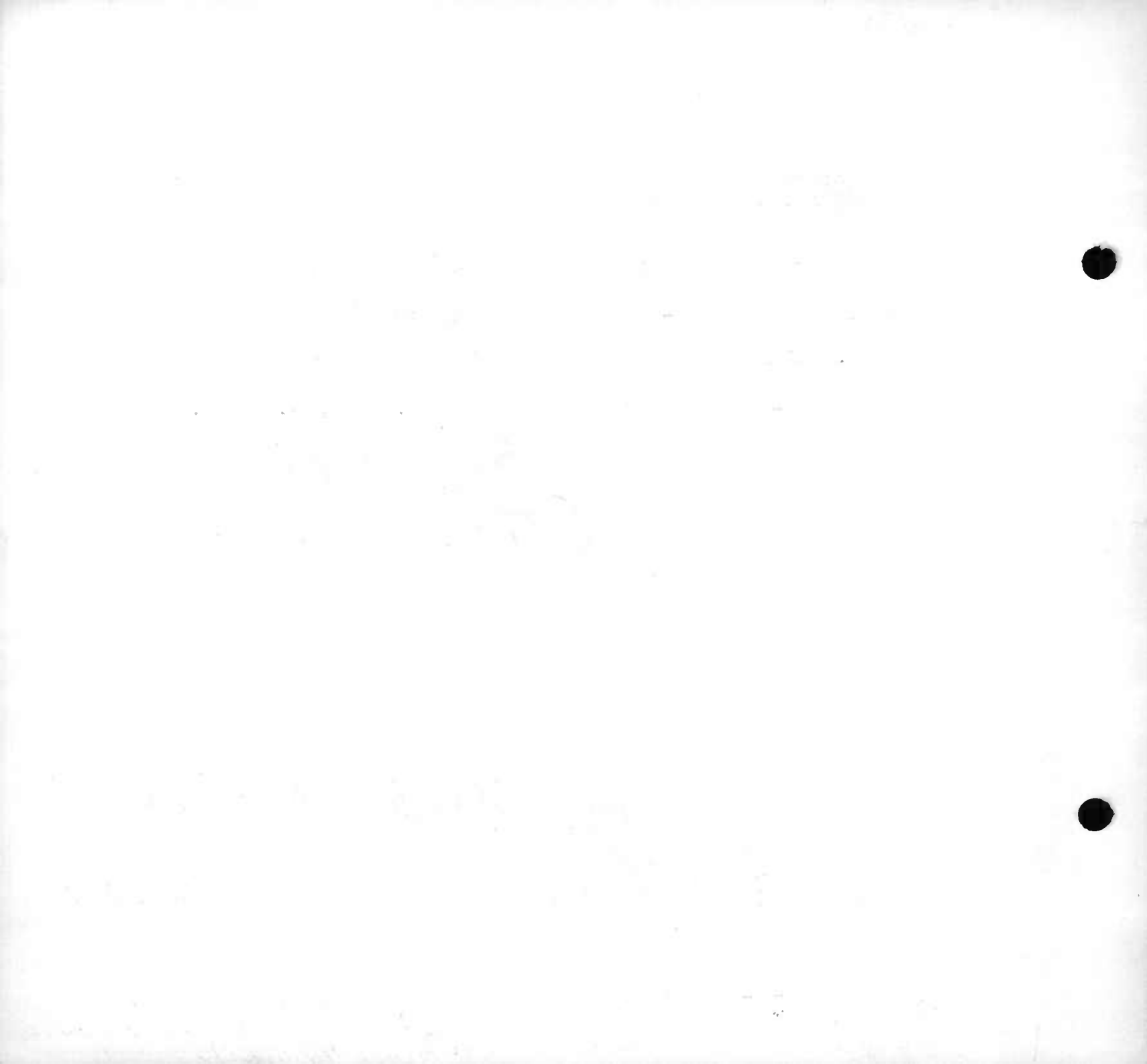
BIRTH NO. M-120		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 3996	
1. NAME OF DECEASED (Type or Print) WILLIAM H. MOEBUIS SR			2. DATE AND HOUR OF DEATH 4/20/71 9:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 5200		
FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL			C. CITY OR TOWN Lake Shore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 42B SWIFT ROAD					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-92	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Maker		10B. KIND OF BUSINESS OR INDUSTRY Candy Mfg		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ?			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			14. MOTHER'S MAIDEN NAME ?		16. SOCIAL SECURITY NO. 212073480
17. INFORMANT Anna C Moebuis			ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca of pancreas					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED jaundice		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-17 19 71 to 4-20 19 71 that (I) (we) last saw the deceased alive on 4-20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R H Neer MD			23B. DATE SIGNED 4-20-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) (R H N)			23D. ADDRESS 513614		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-71		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem	
24D. LOCATION Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Valerie E. Sabes, RD	
25C. FUNERAL DIRECTOR Burgess Funeral Home		ADDRESS Baltimore Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 3997	
B-450		71 3997		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARY C. BLOOM		April 22, 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		1307	
90 Edgewood Nursing Home 6000 Bellona Avenue		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3702 Hickory Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 16 1895	75	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William F. Farley		Alice Ann Williams		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		213 38 5974		ADDRESS	
				Harry A. Bloom, Jr. 1327 W. 41st Street	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from		May 6 1970 to		Apr 7 1971	
that (1) (we) last saw the deceased alive on		Apr 2 1971		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-26-71		Lorraine Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 26 1971		Robert E. Farley, M.D.		Burgee Funeral Home 3631 Falls Rr Balto Md	
				25D. ADDRESS	
				3631 Falls Rr Balto Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-514		71 3998		BALTIMORE CITY HEALTH DEPARTMENT		X		71 3998	
BIRTH NO.		NAME OF DECEASED (Type or Print)		DATE AND HOUR OF DEATH		REG. NO.			
		E. Houston Lampley		4-21-71		L1:03		P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3115 Sollers Point Rd., Balto. Md. 21222					
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-13		9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLISHER		10B. KIND OF BUSINESS OR INDUSTRY STEEL MFG. R.		11. BIRTHPLACE (State or foreign country) Maryland N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME NOAH LAMPLEY				14. MOTHER'S MAIDEN NAME MARY STRICKLAND					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII.				16. SOCIAL SECURITY NO. 241-09-2077		17. INFORMANT BCH Records: 4940 Eastern Avenue Baltimore, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) PNEUMONIA, LEPTIS, HYPOXEMIA DUE TO, OR AS A CONSEQUENCE OF: (C) Complications of aortic insufficiency and aortic valve prosthesis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MINUTES					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/17 19 71 to 4/21 19 71 that (I) (we) lost saw the deceased alive on 4/21 11:05 PM 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Knut S. Alfredson, M.D.				23B. DATE SIGNED 4/21/71				23C. PHYSICIAN'S NAME (Type) Knut S. Alfredson, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		24D. LOCATION (City, town, or county) (State) DORSEY, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971				25B. NAME OF REGISTRAR J. E. [illegible]		25C. FUNERAL DIRECTOR J. E. [illegible]			

1. The first part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

2. The second part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

3. The third part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

1870

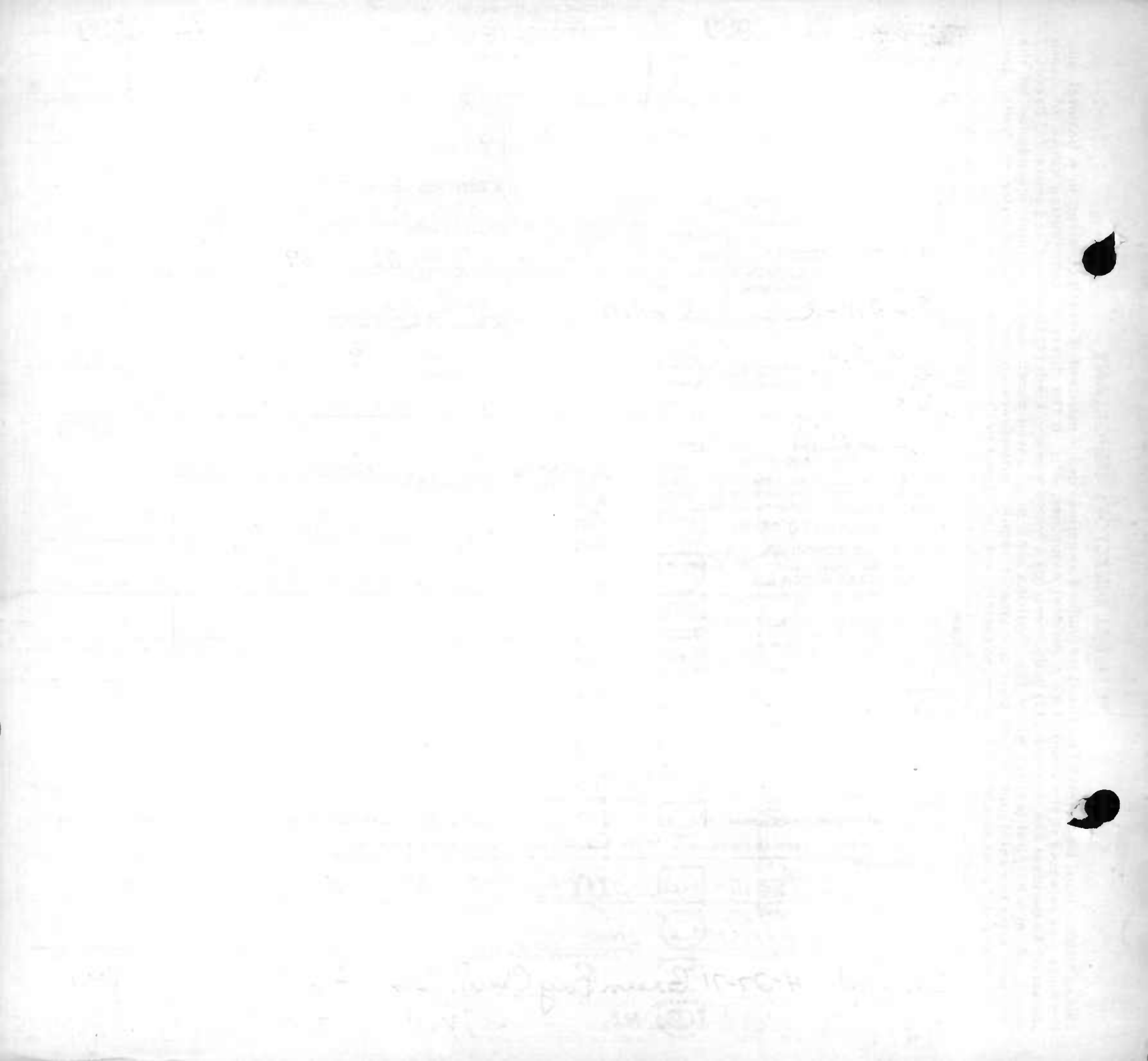
1. The first part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

1870

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. <u>71 3999</u>	
F-530 71 3999 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>POMP FENITY</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		2. DATE AND HOUR OF DEATH <u>April 23, 1971</u> <u>12:50 P.M.</u>	
4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> D.A.C.O. B. COUNTY <u>5200</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5316 Brookwood Rd.</u>		5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-27-1888</u> 9. AGE (In years last birthday) <u>82 yrs</u> 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>U.K.W.</u> 14. MOTHER'S MAIDEN NAME <u>Kate Z.</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No.</u> 16. SOCIAL SECURITY NO. <u>021111111</u> 17. INFORMANT <u>Bethie Keats (daughter)</u> ADDRESS <u>JAME</u>	
18. <u>4-10-01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>Coronary Atherosclerosis + Shock</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Poss.</u> (B) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerosis</u> (C) <u>Hypertensive Atherosclerotic Cardiovascular Disease</u>	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>4-23-71 9:35 AM</u> to <u>4-23-71 12:50 PM</u> 71 that (I) (we) last saw the deceased alive on <u>4-23-71 12:50 PM</u> 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Virginia Fausto-Mercado, M.D.</u> 23B. DATE SIGNED <u>4-23-71</u> 23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA FAUSTO-MERCADO, M.D.</u> 23D. ADDRESS <u>South Baltimore General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>4-27-71</u> 24C. NAME of CEMETERY or CREMATORY <u>Green Bay Church Cem</u> 24D. LOCATION (City, town, or county) (State) <u>Greensboro, Va</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u> 25B. NAME OF REGISTRAR <u>Bessie E. Jones, M.D.</u> 25C. FUNERAL DIRECTOR <u>J. McCully</u> ADDRESS <u>237 Patapsco Ave. Baltimore 1225</u>			



C-560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4000

BIRTH NO.

71-04512

1. NAME OF DECEASED (Type or Print) ANITA L CONROE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 23, 1971 7:55 A.M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard C. CITY OR TOWN Jessup D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/19/71		10. AGE (In years lost birthday) 5 weeks If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James W. Conroe, 1011 Fitzallen Road		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. James W. Conroe, 1011 Fitzallen Road		ADDRESS	
19. CAUSE OF DEATH Sudden death in infancy (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/23/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Witzke, 1630 Edmondson Ave., 21228	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

